State of Alaska
Department of Health and Social Services

Fiscal Year 2003 Budget Overview

Jay Livey
Commissioner

Tony Knowles
Governor

Introduction To Department

Mission

To promote and protect the health and well being of Alaskans.

The Department of Health and Social Services was originally established in 1919 as the Alaska Territorial Health Department. It was established primarily to control diseases and epidemics. The Department continues today to emphasize public health, public welfare and public protection. These core principles are reflected in the mission of the Department (to promote and protect the health and well being of Alaskans) and stem from Article 7, Sections 4 and 5 of the Constitution of the State of Alaska.

In order to carry out our mission, program support is offered in the following areas:

Safety Net Services to Poor, Disabled, and Elderly

- Health Coverage for the Poor: DHSS provides health coverage for the poor with the Medicaid, Denali KidCare, and CAMA programs.

- Cash Based Assistance: DHSS provides cash payments through the Alaska Temporary Assistance Program (Welfare to Work) and Adult Public Assistance Program (monthly cash assistance for poor elderly, blind and disabled).

- Other Assistance programs: DHSS manages the federal food stamp program, Women, Infants and Children (WIC) and Low Income Heating Assistance (LIHEAP) programs that provide food and heating assistance for the poor and disadvantaged.

Protecting Alaskans

- Child Protection Services: Services include investigation, emergency placement, foster care, adoption assistance, residential care and family preservation.

- Juvenile Justice System: DHSS manages the State's juvenile justice system and operates seven detention/treatment facilities.

Public Health

- Protection of Public Health: A variety of public health services are managed and provided by DHSS including: Public Health Nursing Services, Epidemiology, Laboratory, Emergency Medical Services and community health services

Mental Health Beneficiaries

- Alcohol and Drug Abuse Services: DHSS operates through grants to non-profits a wide variety of services to combat alcohol and drug abuse in the state.

- Services for the Mentally Ill & those with Developmental Disabilities: Grants are provided to non-profit entities that provide services in the community for those with mental illness or developmental disabilities. DHSS operates API, the State Psychiatric Institute.

In carrying out these services, we provide the following:

- Benefit payments to 90,000 individuals per month (includes Medicaid eligibility).

- Health Coverage for over 118,000 eligible beneficiaries.

- Over 2,400 positions, of which approximately 1,500 are direct field workers including an estimated 150 Public Health Nurses, 281 Social Workers, 307 Eligibility/Work Services, 270 staff at Alaska Psychiatric Institute (API), 243 Youth Detention/Treatment workers, and 105 Juvenile Probation workers.

- Management of 38 state-owned facilities and 80 leased facilities in over 100 communities in Alaska.

- Management of $137.5 million in grants to communities and non-profit entities throughout Alaska, which provide local jobs to over 2,390 individuals.

- Oversight of over $600 million in federal funds, which flow through the department on an annual basis every year.

To provide these services with a high level of performance, the Department is organized into eight different divisions:

Division of Public Assistance

Division of Medical Assistance

Division of Family and Youth Services

Division of Juvenile Justice

Division of Public Health

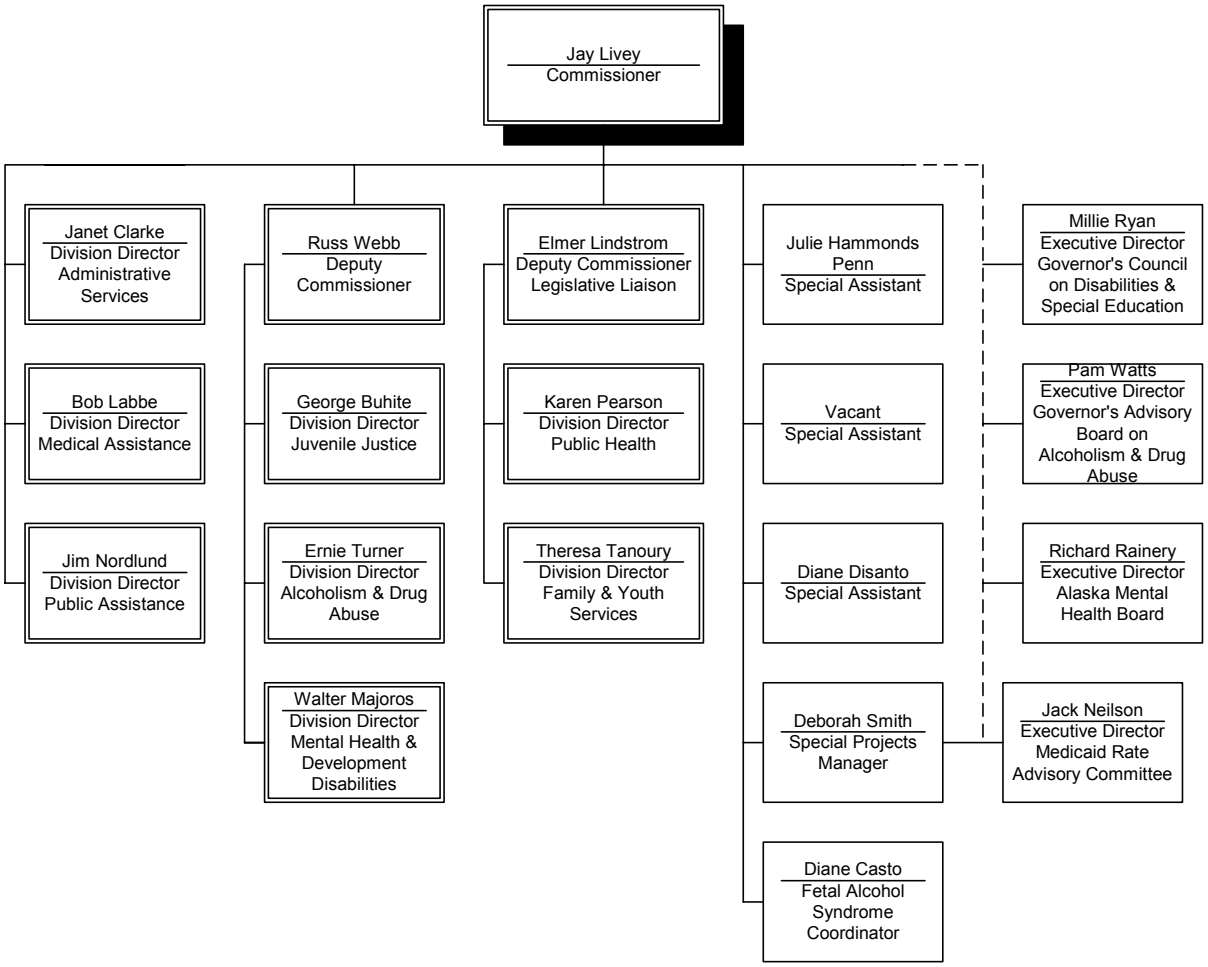
Division of Mental Health and Developmental Disabilities

Division of Alcohol and Drug Abuse

Division of Administrative Services

Executive Management Organization

State of Alaska
Department of Health & Social Services
Executive Management Organization
December 2001



Major Department Accomplishments for FY2001

- To provide better service to the public and meet emerging needs in public health, opened the new Alaska Public Health Laboratory and Office of the State Medical Examiner in Anchorage in January, 2001. Tested scores of samples for anthrax at Alaska Public Health Laboratory, rather than sending them Outside for testing as would previously have been necessary.

- Worked with federal, state, and private contributors to fund Phase 1 of the Code Blue project, which will provide emergency medical services equipment and training in rural Alaska.

- Continued an aggressive immunization campaign to vaccinate all school children and those in day care to meet new requirements.

- Increased the documented Early Periodic Screening Diagnosis and Treatment screening rate from 36% of eligible children to 68% in the current report year.

- Obtained changes to Temporary Assistance Program with federal law exempting Alaska Native villages with high unemployment from the five-year limit; exempting two-parent families with severely disabled children from seasonal benefit cuts; and allowing for uniform application of seasonal two-parent benefits cuts in response to a court decision.

- Alaska ranked 8th in the nation for the percentage of adults in unsubsidized employment and in the average number of hours for adults in unsubsidized employment. Only one state ranked higher in both of these critical measures of welfare reform success.

- The Temporary Assistance for Needy Families caseload declined to 7,421 families in 2001. The average Temporary Assistance caseload was 39% below FY1997, the year before welfare reform was implemented.

- Provided Medicaid coverage through FY2003 for treatment of eligible women who have been diagnosed with breast or cervical cancer.

- Increased efficiencies and streamlined programs and services by consolidating several DHSS offices into the Frontier Building in Anchorage.

- Established a Suicide Prevention Council in statute, with responsibility to develop a statewide suicide prevention plan.

- Began the design-build process to replace the worn-out Alaska Psychiatric Institute facility.

- Through 60+ grantee agencies and an array of for-profit services, provided mental health services to over 20,000 people suffering from mental illness or severe emotional dysfunction.

- Eliminated the Infant Learning Program waiting list.

- The Subsidized Adoption and Guardianship program, which provides permanent homes for children who have been placed in the State's permanent custody, has been very successful. From FY1992 to FY2001, the number of children removed from the foster care system and placed in a permanent home increased 348%, from 338 to 1,515.

- Through the Balloon Project (which provides funding for DFYS and partner legal agencies to focus on moving children on the "transition list" from the foster care system into permanent homes), reduced the growth of the foster parent caseload. In FY1999, the caseload increased by 16.4%; in FY2001, it decreased only 6.2%.

- Provided more thorough training to new child protection social workers through a joint project with the University of Alaska called the Family and Youth Services Training Academy. Approximately 73 new workers completed the primary two-week training course in FY2001.

- Worked with incarcerated kids to provide thousands of community service hours to various agencies and organizations.

- Collected about $20,000 for the Alaska Children's Trust fund through the sale of heirloom birth certificates. Heirloom marriage certificates went on sale in the fall.

- Through the Office of FAS, participated in the development of community diagnostic teams, provided community grants for programs to prevent FAS and support people with FAS and their families, improved data collection, provided information and technical support.

- Together with state and local partners, supported legislation to establish the Tobacco Use Education and Cessation Fund under AS 37.05.580, which provides for 20% of the Master Settlement to be set aside for tobacco education.

- Established Juvenile Alcohol Safety Action Programs around the state and increased outpatient alcoholism treatment capacity in some locations in Alaska.

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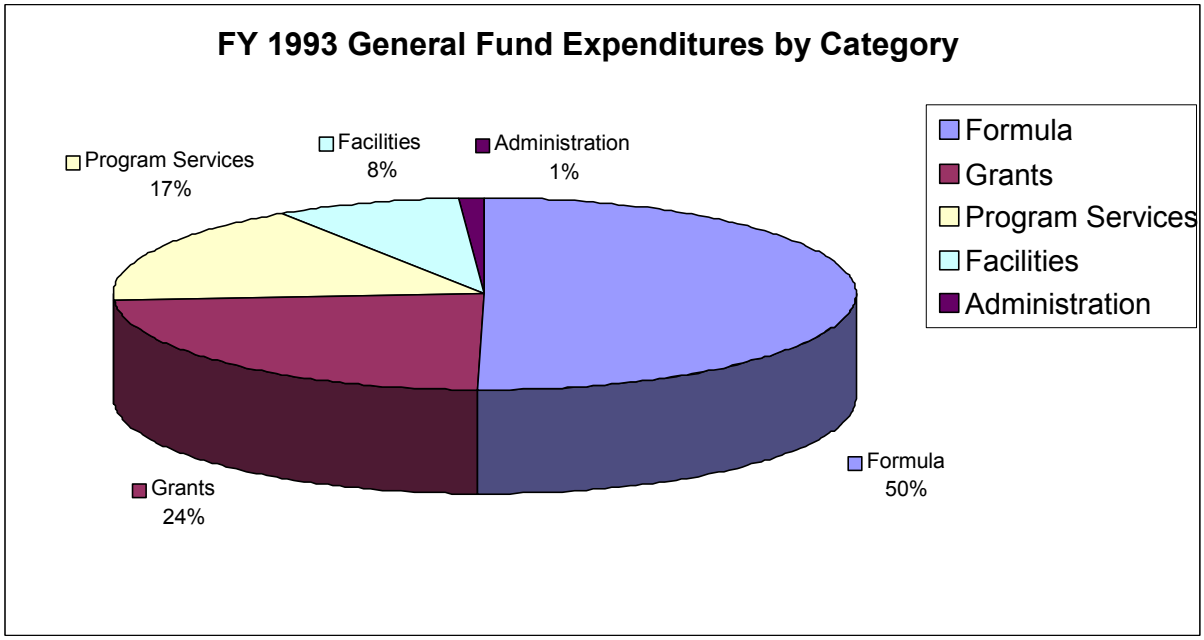
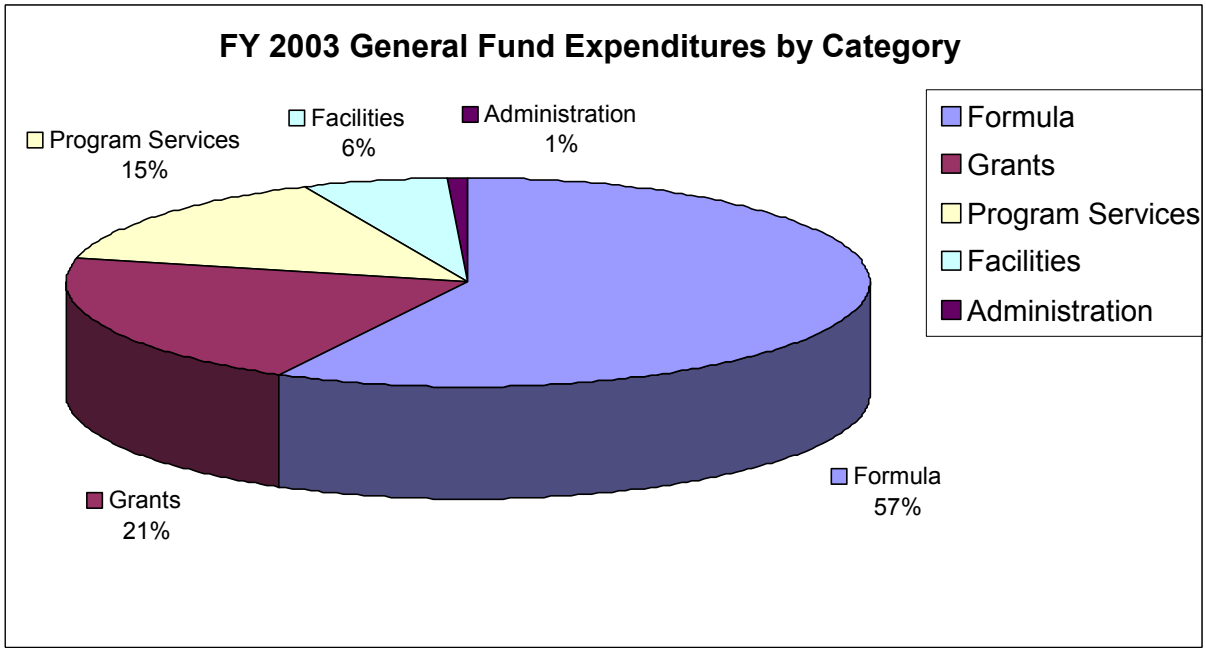
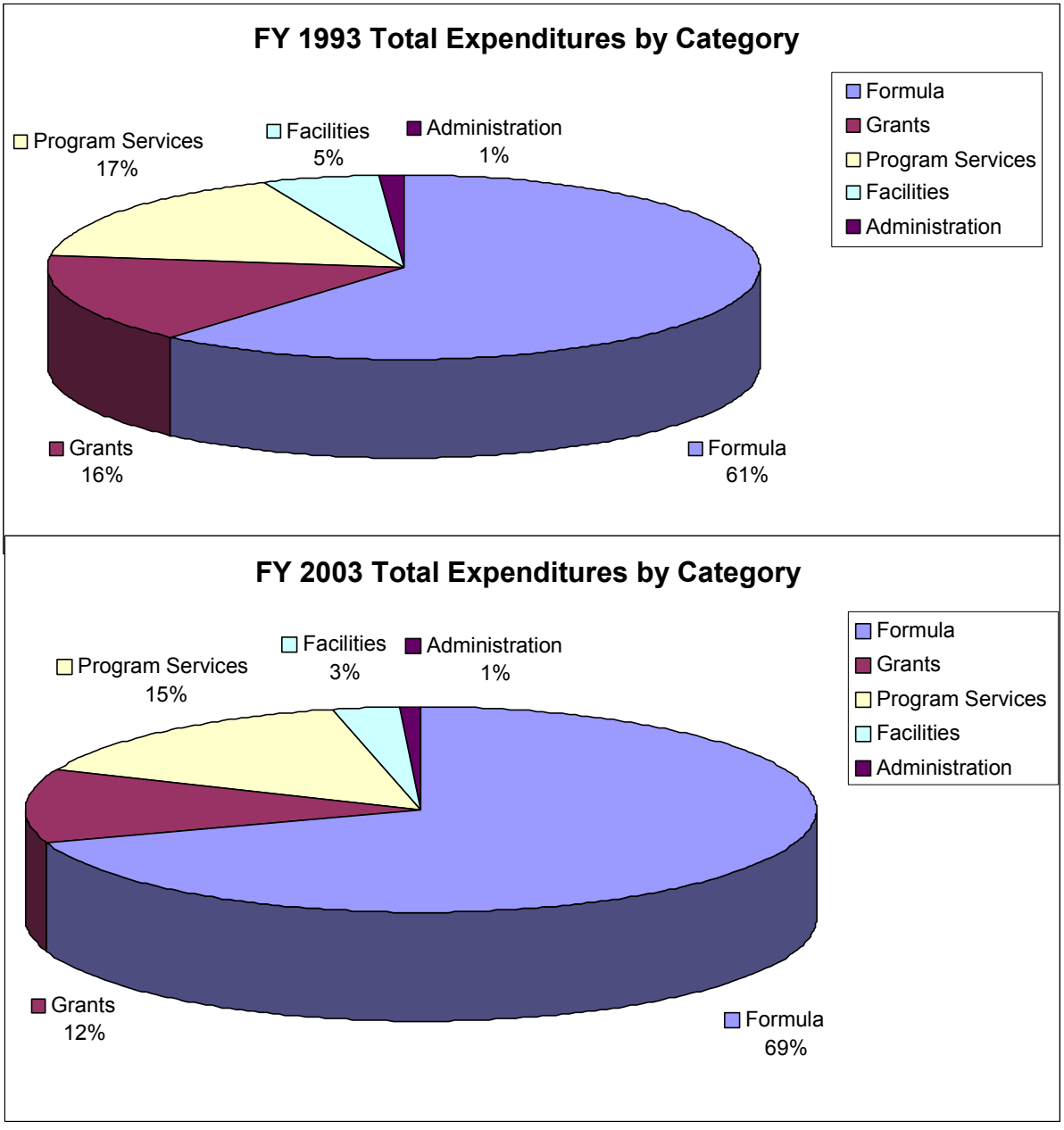
Expenditure Category Comparisons of General Fund Authorization





Expenditure Category Comparisons of Total Funds Authorization



Definition of Categories used in Expenditure Comparisons

Formula Programs include all of the formula programs: Alaska Temporary Assistance Program (ATAP), Adult Public Assistance, General Relief Assistance, OAA-ALB Hold Harmless, Tribal Assistance Programs, Medicaid Services, Catastrophic and Chronic Illness Assistance, Child Care Benefits, Foster Care, Court Orders and Reunification Efforts, and Subsidized Adoption and Guardianship.

Program Services include both administration and delivery of direct services, such as public health nursing and social services, and the administration of entitlements and grants.

Grants include the components with major grants to other organizations or major contracts for service delivery and the Energy Assistance Program.

Facilities include youth correctional facilities and the Alaska Psychiatric Institution.

Administration includes the Commissioner's Office, the other components of the Division of Administrative Services, and the three Mental Health Trust Boards

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Missions and Measures

Mission

To promote and protect the health and well being of Alaskans.

Introduction

The Department of Health and Social Services (DHSS) believes that tracking performance with carefully considered indicators is a critical part of effective management. Over the last several years DHSS has established many performance measures throughout the department, which were used for management purposes. Additionally, over the last few years the legislature has added many more performance measures. During the 2001 Legislative Session, Missions and Measures were adopted in House Bill 250 (Ch. 90, SLA 2001). The next section provides information on the 48 measures added by the Legislature last year.

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Division of Public Assistance

Mission

The mission of the Division of Public Assistance is to promote self-sufficiency and provide basic living expenses to Alaskans in need.

Division of Public Assistance

Measure

The percentage of the Alaska Temporary Assistance Program (ATAP) (AS 47.27) families meeting federal work participation rates.

Sec 77(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

In September 2001, 43% of all Temporary Assistance families were in countable work activities and had sufficient hours to meet the federal participation rate requirements. In December 2001, 53% of Temporary Assistance families were in countable work activities but not all had enough hours of participation to count in the federal participation rate.

According to the U.S. Department of Health and Human Services Third Annual Report to Congress on the TANF program, Alaska ranks 8th nationwide for adults in employment and 7th in the average number of hours for adults in employment. No state ranked higher in both measures of success.

Benchmark Comparison

Federal law requires that states meet work participation requirements:

	Federal Rate All Families	Caseload Reduction Credit	Federal Adjusted Target Rate	Alaska Rate Achieved
FFY 1998	30%	3%	27%	42%
FFY 1999	35%	18%	17%	46%
FFY 2000	40%	29%	11%	39%
FFY 2001	45%	37%	8%	42%
FFY 2002	50%	40%	10%	

FFY 02 Caseload reduction credit and adjustment target rate are estimated.

Every state's federal work participation rate is adjusted by a caseload reduction credit that reflects the state's success in moving families off of assistance and into employment. In FFY 2001, Alaska's caseload reduction credit was 37%. Based on the caseload reduction credit, Alaska's work participation target was 8%. Thus Alaska more than met the adjusted federal participation requirement.

Background and Strategies

Temporary Assistance is a work-focused program designed to help Alaskans plan for self-sufficiency and to make a successful transition from welfare to work. Federal law requires the state to meet work participation requirements. Failure to meet federal participation rates results in fiscal penalties.

As Alaska's TA caseload declines, a growing portion of the families require more intensive services just to meet minimal participation requirements. Enhancement of TA Work Services will serve to identify and address client challenges to participation.

Measure

Rate of job retention among adults receiving Temporary Assistance by region.

Sec 77(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target And Progress

The rate of job retention for Temporary Assistance recipients statewide was 80% in FFY00 and FFY01. The method used to measure job retention mirrors that required by the federal government for the TANF High Performance Bonus, using quarterly data from the Alaska Department of Labor.

Rate of Job Retention by region:

Central	80%
Coastal	80%
Southeast	79%
Northern	79%

The DPA goal for job retention by Temporary Assistance recipients in FFY02-03 is 80%.

Job retention is measured for a period of 12 months and the recipient must be working in each quarter during the 12-month period.

Background and Strategies

Job retention enables families to reduce or eliminate dependency on welfare. Case management, supportive services and childcare payments are important services which help to improve job retention.

Most often, those Temporary Assistance adults who have the best ability to retain employment are the most likely to leave the caseload. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload it is increasingly difficult to maintain high job retention percentages.

Measure

Percentage of ATAP adults who have left assistance because they become employed who are receiving day care assistance.

Sec 77(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

In FY2001, 20% of ATAP adult-included families who left assistance with earnings and a child less than 12 years old received PASS II child care.

Background and Strategies

Working families who have left Temporary Assistance (PASS I) are guaranteed one year of transitional child care (PASS II) if they need it. The PASS II program is administered by the Department of Education and Early Development. This measure indicates the use of transitional (PASS II) child care assistance by Temporary Assistance clients who have worked their way off of welfare.

In FY01, an average of 151 notices per month were sent to working families who had recently left Temporary Assistance (the cases were closed), informing them about the availability of PASS II child care assistance.

Measure

The percentage of adults receiving temporary assistance who have earned income.

Sec 77(b)(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

Percentage of Temporary Assistance adults with earned income was 31% in September 2001.

The percentage of families leaving Temporary Assistance who reported earnings when they left was 38% in September 2001.

Goal for FY02-03 is 45% of Temporary Assistance adults with earned income, and 45% of case closures with reported earned income.

Background and Strategies

This is a measure of current Temporary Assistance recipients who have earned income. As the caseload declines, those adults with more significant barriers to employment make up a higher percentage of the caseload. Therefore, with a declining caseload, it becomes more difficult to achieve higher percentages of recipients with earned income. The goal of the division's welfare-to-work effort is to move families off assistance and into a job that pays well enough for the family to be self-sufficient. Case management, supportive services, child care and other services are critical to the success of this effort.

Division of Public Assistance

Measure

The rate of payment accuracy for ATAP payments & Food Stamps.

Sec 77(b)(5) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

Temporary Assistance payment accuracy rate was 96% in FFY01.

In FFY98, FFY99 and FFY00 the Food Stamp accuracy rate was 88%, 84%, and 93% respectively. Food Stamp state-calculated payment accuracy rate was 91% for FFY01 as of 10/22/01. FFY01's federally calculated payment accuracy rate will be available April 2002.

The goal for FY02-03 is 94% accuracy in Food Stamps and 98% accuracy in Temporary Assistance.

Benchmark Comparison

The US Department of Agriculture determines acceptable performance for Food Stamp payment accuracy for all states by using a national average after the end of the federal fiscal year (September). States with accuracy rates worse than the national average can receive fiscal penalties. The national average for FFY01 is anticipated to be approximately 90%. In FFY 01 the state calculated Food Stamp accuracy rate was 91%. USDA publishes the national average in the spring each year.

Background and Strategies

Accurate benefits ensure clients have the amount of benefits to which they are entitled. Fluctuating benefits cause budget issues for clients and impact their ability to gain self-sufficiency. The Quality Assessment Reviews evaluate payment accuracy using statistically valid desk reviews.

The failing accuracy rates in FY98 and FY99 were due in large part to the dramatic changes caused by the implementation of welfare reform. Through a settlement with USDA, the Division reinvested a portion of the penalty in a program to improve the rate which resulted in remarkable success during FFY00.

Division of Medical Assistance

Mission

The mission of the Division of Medical Assistance is to maintain access to health care and to provide health coverage for Alaskans in need.

Division of Medical Assistance

Measure

The average time the division takes from receiving a claim to paying it.

Sec 78(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

During the last half of FY01, it took an average of 11.08 days to pay claims.

Benchmark Comparison

Federal regulation requires that 90% of all clean claims received must be paid within 30 days, and 99% of all clean claims received must be paid within 90 days (42 CFR 447.45 Time of Claims Payment).

Background and Strategies

The assumption is that the timely payment of medical claims gives providers incentive to participate in the Medicaid Program. Therefore, the legislature and the division are interested in a measure of how timely the division responds to or pays claims.

Division of Medical Assistance

Measure

The percentage of claims with no errors categorized by the type of provider.

Sec 78(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

Provider Type	Percentage of "Clean Claims"
Pharmacies	80.23%
Dentists	72.96%
Nursing Facilities	69.75%
Physicians	69.01%
Hospitals	57.45%
All Providers	**72.64%**

The percentage of error-free claims reported for FY00 was 73.54%. Only two provider categories reported decreased percentages: physicians and dentists -- both had a less than 1% change from last year.

Benchmark Comparison

The division has requested comparable information from other states, but has not yet received responses to those requests.

Background and Strategies

This is a measure of the providers ability to file error-free claims which reduces the time and effort required to process claims. Those provider types experiencing more problems filing error-free claims are targeted for additional training. We assume that providers who do not experience problems in getting claims paid are much more likely to continue participating in the Medicaid Program.

Division of Medical Assistance

Measure

The percentage of total funds that are used to pay claims compared to the percent used for administration of the division.

Sec 78(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

	Current Year (FY01)	Previous Year (FY00)
Claims Payments	96.7%	96.3%
Division Administrative Costs	3.3%	3.7%

Benchmark Comparison

The HCFA publication "Medicaid Statistics Program and Financial Statistics Fiscal Year 1998", the most recent statistical information available, reports a 4.13% administrative cost versus a 95.87% for program payments. The source documented is the HCFA 64.

Background and Strategies

This is a fiscal measure of the State's administrative overhead necessary to support the medical assistance programs.

Measure

The percentage of the providers who are participating in the medical assistance program by region.

Sec 78(b)(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

Provider Type	Providers Licensed by State of Alaska		Providers Paid at Least Once Medicaid Claim		Percent of Participating Providers	
	FY00	FY01	FY00	FY01	FY00	FY01
Physicians**	1,287	1,282	662	650	51%	51%
Dentists	412	431	221	216	53%	50%
Pharmacies	97	115	74	81	76%	70%
Hospitals	16	16	16	16	100%	100%
Nursing Facilities	15	15	15	15	100%	100%

** The total number of unduplicated physicians who had at least one paid claim during FY01 was 815. The discrepancy between the total of 815 and the 662 licensed physicians charted above can, at least in part, be attributed to the exclusion of Indian Health Services (IHS) physicians in the Occupational Licensing database. IHS physicians are not required to be licensed by the State of Alaska.

We feel we are making progress in our goal of increasing provider participation, but are still unable to measure any success effectively.

Background and Strategies

This is a measure of Alaska's medical assistance clients' access to medical services through the same network of medical providers available to the balance of the State's population.

The Division continues to work towards complying with this Performance Measure requirement. However, we have had some difficulties.

To provide geographical information on providers, each provider must be matched by city. Therefore, the definition of each region needs to be defined clearly and each city pointed to a region to establish a total.

In addition, provider enrollment data in MMIS has not been purged since 1979. The number of enrolled providers exceeds 8,000. A data purge would be a lengthy and expensive undertaking, and for that reason, has not been done. This means MMIS fiscal year claim payment data must be compared to Occupational Licensing data - two separate databases without comparable data parameters. For instance, a provider may have several Medicaid provider ID's, one for each rendering address, each in a different region, but only one address within the Occupational Licensing file. A further complication arises because physicians practicing in the Medicaid

program through the Indian Health Services need not be licensed with the State of Alaska and will not be included in the Occupational Licensing database.

It is also extremely difficult to identify unduplicated providers within a region and match them with comparable claims paid data. For example, a physician licensed to practice in the State of Alaska may do so through several different facilities in several different regions.

The division will continue to define and refine its methodology to respond to this measure in the most effective way possible.

Division of Family and Youth Services

Mission

The mission of the Division of Family and Youth Services is to protect children who are abused and neglected or at risk of abuse and neglect.

Division of Family and Youth Services

Measure

The number of children substantiated as abused or neglected and the number of children unconfirmed as abused or neglected by region.

Sec 79(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

1) The number of children substantiated as abused or neglected:

FY1997	3,267 of 7,563 (43.2%) children substantiated as abused or neglected
FY1998	3,690 of 8,128 (45.4%) children substantiated as abused or neglected
FY1999	3,568 of 7,592 (47.0%) children substantiated as abused or neglected
FY2000	3,266 of 6,598 (49.5%) children substantiated as abused or neglected
FY2001	4,122 of 8,865 (46.5%) children substantiated as abused or neglected

2) The number of children substantiated as abused or neglected by region:

FY2001	
Anchorage Region	1,338 of 3,249 children
Southcentral Region	1,232 of 2,335 children
Northern Region	1,246 of 2,361 children
Southeast Region	306 of 920 children
FY2001 Total	4,122 of 8,865 children

3) The number of children unconfirmed as abused or neglected by region:

FY2001	
Anchorage Region	1,700 of 3,249 children
Southcentral Region	908 of 2,335 children
Northern Region	879 of 2,361 children
Southeast Region	448 of 920 children
FY2001 Total	3,935 of 8,865 children

Background and Strategies

Workers conclude every assigned investigation with a determination that the report of harm was substantiated, unconfirmed, or invalid. A substantiated report of harm is one where the available facts indicate a child has suffered harm as a result of abuse or neglect as defined by AS 47.10.011. An unconfirmed report of harm is one where, based on the available facts, the worker is unable to determine if a child has suffered harm as a result of abuse or neglect. An invalid report is one where there are no facts to support the allegation that a child has suffered abuse or neglect.

This measure is also required for the Federal Review. The Federal Review is conducted by the U.S. Department of Health and Human Services.

The Federal Review measure most related to this State measure is *Disposition*

of Child Abuse and Neglect Reports. This measure is based on the disposition or finding of any child who was the subject of an investigation in a particular report, and includes the number and percentages of reports and of children. For this measure, the division reports the:

Number of children who had a substantiated or unconfirmed report.

The division recommends that the same measure for the Federal Review be used for this State measure in the future.

Division of Family and Youth Services

Measure

The incidence of child abuse or neglect in foster care.

Sec 79(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The Division's target is zero incidences of child abuse or neglect in foster care.

Number Of Children With Substantiated Incidents Of Maltreatment In Licensed Foster Care By Region and By Type of Maltreatment FY 01 (Legislative Outcome Data)

Region	Number of Children	Physical Abuse	Sexual Abuse	Neglect	Emotional Injury	Abandon-ment
NRO	15	5	0	10	0	
SC	9	4	2	1	2	
ARO	8	5	0	2	1	
SE	1				1	
Total All Regions	**33**	**14**	**2**	**13**	**4**	**0**

Background and Strategies

Background:

These 33 children were represented in 22 foster homes, less than 2 percent of the total licensed foster homes during this period of time.

Of the 22 foster homes, 11 of them closed as a result of the substantiated finding, 7 of them remained licensed with the child placed in the home, 2 of them were closed due to an adoption by a foster parent who was also a relative to the child, and 2 of them remain licensed without the child placed in the home. All of the homes that did not close as a result of the substantiated finding were either counseled, consulted, or had a plan of correction, and they succeeded in their plan of correction.

In response to a substantiated finding in a foster home, the division usually offers advise and consultation to correct the foster parent's behavior, a formal plan of correction which might include training for the foster parent, a license modification such as reducing the number or age range of children cared for, or formal revocation of the foster license. If the child has been previously removed, a decision will be made if the removal is to become permanent. The decision on whether to remove a child after a substantiated finding is impacted by many variables. These include consideration of the nature and seriousness of the incident as well as the foster parents' response. The duration and level of the foster parent and foster child relationship is considered. The wishes of the foster child, if age appropriate, are considered. The safety of the child is paramount in any decision that is made.

Strategies:
The Federal Review also includes this same measure. It is defined as follows: Of all children who were served in foster care during the reporting period, what percentage was the subject of substantiated or indicated (unconfirmed in Alaska) maltreatment by a foster parent or facility staff? Both the percentage and total number of children are provided. This group also includes relatives who are caring for children in state custody.

- *Continue the APSIN Flag program.* This program is a collaborative, on-going effort between the Department of Public Safety and the Division of Family and Youth Services. All licensed caregivers are entered into APSIN and if there is ever a police response to the home, the division is immediately notified.

- *Provide Foster Parents and Relative CareGivers the support and information they may need.* Essential to meeting this strategy is a effective training program for caregivers. The division offers training to all licensed caregivers and tracks the amount of training each foster parent receives annually.

Division of Family and Youth Services

Measure

The number of children in state custody longer than 18 months and 36 months.

Sec 79(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for this measure is no child waits longer than 2 years or more to leave state custody

FY2001 1,049 of 1,937 (54 percent) children were in state custody for 18 months or longer.

FY2001 501 of 1,937 (26 percent) children were in state custody for 36 months or longer.

Background and Strategies

The Federal Review has two related measures that are defined as follows:

Median length of stay in foster care; and

Number of children in care 17 of the most recent 22 months.

The division recommends that the same measure for the Federal Review be used for this State measure in the future. The division is currently working on developing the new data and it will be available by the end of January 2002.

Division of Family and Youth Services

Measure

The length of time in state custody before achieving adoption.

Sec 79(b)(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for this measure is 6 months from termination of parental rights.

FY1997	17.4 months
FY1998	19.8 months
FY1999	14.5 months
FY2000	15.1 months
FY2001	12.0 months

Background and Strategies

This measures the length of time in months to achieve adoption from the point in time when both parents' rights have been terminated or when they relinquish their rights to the point in time when the adoption is final.

Alaska's length of time has been declining since 1998.

The division has undertaken a number of programs that have been and continue to be fundamental in achieving a shortened time frame before a child achieves adoption, they are:

* *Continue Adoption Placement Program (Balloon Project) and Project Succeed*
* *Promote the Alaska Adoption Exchange*
* *Provide training to adoptive parents with special needs children*
* *Implementation of SNAP, the Simple New Adoption Process*
* *Continue the Home study Project*

Measure

The average length of time in state custody before achieving reunification.

Sec 79(b)(5) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for this measure is to maintain FY2001 timeframe of 9.6 months.

FY1999	9.3 months
FY2000	9.9 months
FY2001	9.6 months

Benchmark Comparison

The Federal Review has a related measure that is a comparison across States. The measure is defined as follows:

> Of all children who were reunified with their parents or caretakers at the time of discharge from foster care, what percentage was reunified in less than 12 months from the time of the latest removal from home.

The division recommends that the same measure for the Federal Review be used for this State measure in the future. It is crucial that proposed actions to establish family visitation centers to maintain this timeframe or even to improve the current time frame.

Background and Strategies

Many factors contribute to when reunification can or should occur. Workers consider progress and change on the part of the family members in remedying the situation that caused the child to be removed when considering reunification. A premature reunification can lead a child back into custody and placement outside of his or her home, so it is important that the timing is right for the family. Likewise, a delay in reunification can lead to frustration and a loss of any progress made by the parents or family members.

Division of Family and Youth Services

Measure

The number of child-days that foster homes were found to be beyond license capacity by location.

Sec 79(b)(7) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for this measure is 0 child-days.

In FY2001 only one foster home was beyond license capacity:

Anchorage: 1 foster home beyond capacity for 9 days

Background and Strategies

Licensing requirements specify no more than two children in each foster home is allowed. However, there are instances where variance or exemptions are made to this requirement. It mostly occurs when groups of siblings are placed together. Any licensed foster home with more than two children receives special variance or exemption.

There is no related measurement for the Federal Review, although, the Review will look for instances where siblings are not placed together. There should be well-documented reasons for not placing siblings together.

Division of Family and Youth Services

Measure

The number of closed cases in which there is a reoccurrence of maltreatment.

Sec 79(b)(6) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for this measure is 13 percent by FY2003. The national standard used for this measure in the Federal Review is 6 percent.

FY1999 962 of 4,147 (23.2%) closed cases had a reoccurrence of maltreatment
FY2000 1,212 of 4,592 (26.4%) closed cases had a reoccurrence of maltreatment
FY2001 999 of 4,233 (23.6%) closed cases had a reoccurrence of maltreatment

Background and Strategies

This measure is the same as one used in the Federal Review. Recurrence of Maltreatment is defined as follows:

> Of all children who were victims of substantiated or indicated (unconfirmed in Alaska) child abuse and/or neglect during the first 6 months of the reporting period, what percentage had another substantiated or indicated report within a 6-month period?

The Federal Review will provide more of an analysis of why so many children are being re-reported. Once the analysis is completed the division will develop action plan to achieve the national standard of 6%.

Measure

The percentage of legitimate reports of harm that are investigated.

Sec 79(b)(8) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for this measure is 100 percent of all legitimate reports of harm will be investigated.

FY1997	73.6 percent
FY1998	77.3 percent
FY1999	78.1 percent
FY2000	88.8 percent
FY2001	90.7 percent

Background and Strategies

Reports of harm are prioritized according to the immediate or potential risk of harm to the child. A priority 1 rating is the most serious and must be responded to within 24 hours from the time the Division receives the report. Priority 2 reports of harm must be responded to within 72 hours of receipt of the report. Priority 3 reports are considered low risk and must be responded to within one week of receiving the report.

Early intervention for family support enables the Division to focus more social workers on investigating higher priority reports of harm. This allows for early intervention that minimizes the risk to children and often negates the need for out-of-home placements or further intervention.

Not enough staff seriously effects the Division's ability to respond to all legitimate reports of harm. More staff is needed. More efficient work processes are needed. The division is working on a new MIS system.

Division of Family and Youth Services

Measure

The turnover rate of the Division of Family and Youth Services staff by region.

Sec 79(b)(9) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for this measure is 10 percent turnover rate in all regions.

Statewide	FY1998	32.60 percent
	FY1999	32.54 percent
	FY2000	21.53 percent
	FY2001	24.84 percent

FY2001 by Region

Anchorage	29.17 percent
Southcentral	12.73 percent
Northern	24.75 percent
Southeast	28.26 percent

Background and Strategies

There are many reasons why staff leave their jobs. Chief among those reasons include caseload size, relationship with supervisor, and low salary. Caseload size in Anchorage office drove the increase between 2000 and 2001. Caseloads were more than double the national standard. The difficulty in recruitment delayed some hires which caused caseloads to remain high through staff vacancy periods.

In July 2001, the minimum qualifications for social workers changed, now requiring high qualifications to do the same job. The job market is very competitive, making salaries lower than usual for the type of work and qualifications needed.

Division of Family and Youth Services

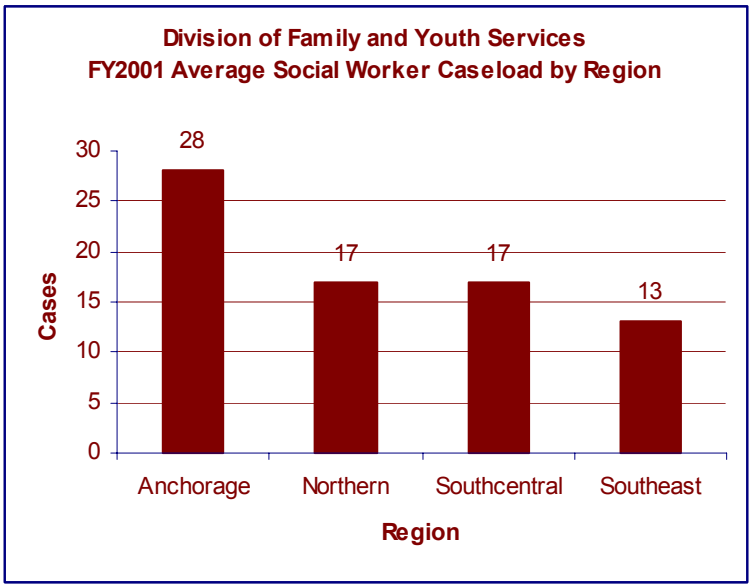
Measure

The average social worker caseload by region.

Sec 79(b)(10) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The Division's target is 15 families per worker.



Background and Strategies

National caseload standards established by the Child Welfare League were used for comparison. The Child Welfare League's national caseload standard for the Anchorage region is 15. The national standard for the Southcentral Region is 13. The national standard for the Northern Region is 14 and for the Southeast Region 14. The national statewide total is 14 cases per worker.

The FY 2001 Southeast Region workload was 13 cases per employee. This represents the average for the region. Although the workload of the field offices such as Juneau, and Ketchikan exceeds the national workload standard, single employee offices has less than the national average resulting in a caseload less than the national average. These single employees offices are crucial to provide services to these communities and often their work in the community reduces the child abuse and neglect.

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Division of Juvenile Justice

Mission

The mission of the Division of Juvenile Justice is to protect and restore communities and victims while holding juvenile offenders accountable for correcting their behavior.

Division of Juvenile Justice

Measure

The percentage of Juvenile Offenders that Re-Offend.

Sec 80(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The percentage of Juvenile Offenders during FY2001 that Re-Offended was 46%. This is down from the FY2000 rate of 65%.

This measure consists of the re-offense rates of youth who have been released from a Juvenile Justice long-term treatment facility. A recidivist is a youth who, within 24 months of release from a long-term treatment facility, has obtained either: a new juvenile institutional order or, a new juvenile adjudication or an adult conviction.

Background and Strategies

It is important to understand that this recidivism performance measure focuses on a small, albeit significant, portion of the Division of Juvenile Justice's clientele. The Division works effectively with a much larger client base. For example, in FY 2001, 4,864 juveniles (unduplicated count) were referred to the Division. Of this number, 2693 (55%) responded quickly to intervention and did not require ongoing formal probation services, nor did they penetrate further into the system. Of the 2,171 who required probation supervision, only 220 (10%) received B1 court orders for placement in the Division's secure long term treatment facilities. While the FY 2001 recidivism data reported in this measure does not track the results of these specific 220 juveniles (because they have not been released in this fiscal year), these numbers are illustrative in understanding that the bulk of the work done by the Division is with juveniles who are **not** placed in secure facilities.

The Division of Juvenile Justice engaged in a series of involved internal discussions on re-offense measures before establishing the criteria used to produce this performance benchmark. Setting the benchmark to trigger the re-offense count at the point of conviction or subsequent adjudication eliminated those contacts with law enforcement which were dismissed or never pursued by the prosecutor. The established benchmark also excluded minor violations such as fish and game and traffic offenses which are not necessarily always indicative of criminal behavior.

The two-year time frame set a stringent standard for the Division, but with this time frame as the benchmark, the Division felt the measure was a reliable indicator as to the effectiveness of the Division's efforts to positively impact the non-re-offense rates by those who went through our programs. There is no single, nationally accepted re-offense standard or definition. Jurisdictions around the country vary widely in the way they measure re-offense data. Alaska's definition and re-offense outcome measure was structured in a fashion which the Division believes strikes a balance between what we

believe can be reasonably measured while assessing criteria which give the Division, the Legislature and the public a meaningful measure to assess the effectiveness of the Division's programs and services.

Division of Juvenile Justice

Measure

The percent of ordered restitution and community work service that is paid or performed by the Juvenile Offender.

Sec 80(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The FY2001 statewide Division of Juvenile Justice amount of Restitution ordered was $349,660 and the amount paid by juvenile offenders was $306,674, or 87.7% of what was ordered.

The FY2001 statewide Division of Juvenile Justice amount of Community Work Service hours ordered was 28,926 and the amount performed by juvenile offenders was 25,616, or 88.6% of what was ordered.

For the restitution measure the benchmark is 79%.
For the community work service measure the benchmark is 83%.

Background and Strategies

This performance measure consists of two components that provide a gauge of the Division of Juvenile Justice's effectiveness with assisting delinquent youth in being accountable to his or her victim and community for their delinquent behavior, as well as the youth providing restoration to his or her victim and community for their delinquent behavior.

This measure consists of:

-The percentage of restitution paid for cases where there was a restitution order (either by the court or the Probation Officer). This measure shall be determined at case closure. Case closures occur when a court order has been given to close a case, a court order has expired, or informal adjustment has been made by the Probation Officer.

-The percentage of community work service performed for cases where there was a community work service order (either by the court or the Probation Officer). This measure shall be determined at case closure. Case closures occur when a court order has been given to close a case, a court order has expired, or informal adjustment has been made by the Probation Officer.

Division of Juvenile Justice

Measure

The number of escapes from Juvenile Institutions.

Sec 80(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The following table reflects the institution escapes in FY2000 & FY2001

Division of Juvenile Justice		
Institutional Escapes		
Facility	**FY2000**	**FY2001**
Bethel Youth Facility	1	0
Fairbanks Youth Facility	2	*6
Johnson Youth Center	0	0
Mat-Su Youth Facility	**NA	2
McLaughlin Youth Facility	4	0
Nome Youth Facility	0	0
Total	**7**	**8**

*Four Fairbanks residents escaped during an outing to an Alcoholics Anonymous Meeting.

**The Mat-Su Facility opened in October 2000.

The benchmark for this measure is the average number of escapes that occurred during FY1995 through FY1997: 9.

Background and Strategies

This performance measure provides a gauge of the Division of Juvenile Justice's effectiveness in providing safety to communities.

This measure consists of the number of youth in Juvenile Justice custody who escape from a Juvenile Justice institution. An escape is defined as an unauthorized departure of a youth from a secure juvenile facility or a secure unit in a facility, or from a direct staff-supervised activity such as court escort, a transfer to another facility, or supervised community activity.

Division of Juvenile Justice

Measure

Rate of recidivism of youth in the juvenile justice system by region and by race.

Sec 80(b)(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The following table reflects the rate of recidivism of youth in the juvenile justice system by region and by race.

Division of Juvenile Justice
Institutional Recidivism By Region
FY2001

Facility	Baseline*	# Youth Released	FY2001 Reoffended	% Reoffended
Bethel Youth Facility	70%	8	6	75%
Fairbanks Youth Facility	65%	19	6	32%
Johnson Youth Center**	NA	NA	NA	NA
McLaughlin Youth Facility	47%	106	49	46%
Total	65%	133	61	46%

*The baseline for youth facilities was established by averaging the rates of recidivism for each facility. For McLaughlin Youth Center there is more than ten years of data available. For all of the other facilities there is less data and comparisons should be viewed with caution. Additionally, there are wide variations from year-to-year with McLaughlin data and the overall trend is more significant than any of one year of data.

** The treatment unit at Johnson Youth Center opened April 1999 and did not release youth until FY2000.

The target for the facilities is to maintain or decrease recidivism from the established base line which was established at a re-offense rate of 65% in FY2000 for all DJJ facilities. FY2001 data shows a decrease in the overall statewide rate to 46%.

Division of Juvenile Justice
Institutional Recidivism By Race

Race	**Youth Released**	**Youth Who Re-Offended**	**Recidivism Rate**
Caucasian	78	31	40%
African American	13	6	46%
Native American	32	18	56%
Asian/Pacific Islander	5	2	40%
Unknown	5	4	80%
Total	**133**	**61**	**46%**

The recidivism rates should be interpreted with caution as they are based on a small number of occurrences. No statistically significant difference exists in the rate of recidivism by race.

The division recognized that establishing recidivism as a performance measure would prove to be difficult and potentially problematic. While it is intuitive that recidivism should be measured there is no single, nationally accepted re-offense standard or definition. Very few states even attempt to measure recidivism and for those that do the standards vary widely. For example, one common measure used by facilities is to only count those juveniles who return to their facility as a recidivist. Cleary this excludes a whole range of circumstances, i.e. juvenile is too old, moves out-of-state, commits an offense but is not returned to the facility, all of which increase the success rate of the facility. Similarly, Oregon, which is recognized as one of the leading states in the field of juvenile justice, does not track juveniles past the age of juvenile jurisdiction, or eighteen or those who enter the adult system. Alaska's measure, by contrast, tracks juvenile offense history for two years from the time a juvenile is released from a youth facility, irrespective of age, and accesses adult arrest records to determine if there is no new offense activity. By establishing a two-year measure the Division believes that the results are a strong indicator of the programs impact on juvenile offenders.

The Division's re-offense outcomes measure strikes a balance between what we believe can be reasonably measured while assessing criteria to provide a meaningful measure to assess the Division's progress in providing effective programs and services to juveniles.

Background and Strategies

It is important to understand that this recidivism performance measure focuses on a small, albeit significant, portion of the Division of Juvenile Justice's clientele. The Division works effectively with a much larger client base. For example, in FY 2001, 4,864 juveniles (unduplicated count) were referred to the Division. Of this number, 2693 (55%) responded quickly to intervention and did not require ongoing formal probation services, nor did they penetrate further into the system. Of the 2,171 who required probation supervision, only 220 (10%) received B1 court orders for placement in the Division's secure long term treatment facilities. While the FY 2001 recidivism data reported in this measure does not track the results of these specific 220 juveniles (because they have not been released in this fiscal year), these numbers are illustrative in understanding that the bulk of the work done by the Division is with juveniles who are **not** placed in secure facilities.

This measure consists of the re-offense rates of youth who have been released from a Juvenile Justice long-term treatment facility. A recidivist is a youth who, within 24 months of release from a long-term treatment facility, has obtained either: a new juvenile institutional order or, a new juvenile adjudication or an adult conviction.

See performance measure "The percentage of juvenile offenders that re-offend" for more detailed discussion of re-offender data.

Division of Juvenile Justice

Measure

The number of juvenile offenders who are maltreated while in state custody.

Sec 80(b)(5) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The following table reflects the number of juvenile offenders who were maltreated while in state custody.

Division of Juvenile Justice Custodial Maltreatment	
Facility or Probation Region	*1st Quarter FY2002
Anchorage Region	4
Southcentral Region	0
Southeast Region	0
Northern Region	1
Total	5

*Covering the period of July 1, 2001 through September 30, 2001.

During an average fiscal year quarter, the Division of Juvenile Justice has approximately 750 youth in custody at some point during the quarter.

Background and Strategies

This measure consists of the number of Division of Juvenile Justice's youth who are the subject of a report to either the Division of Family Youth Services or a law enforcement agency that alleges maltreatment (i.e., neglect, physical abuse, sexual abuse, abandonment, or mental injury), where the alleged maltreatment occurred when the youth was in the legal custody of the Division of Juvenile Justice, regardless of where the child was placed. Placement could be in a youth facility, foster care home, or in a resident treatment home.

Division of Public Health

Mission

The Mission of the Division of Public Health is to preserve and promote the state's public health.

Division of Public Health

Measure

The percentage of two-year-old children in the state who are fully immunized

Sec 81(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target by 2010 is 90% of all 2 year olds fully immunized.

The percentage of fully immunized 2-year-olds for calendar year 2000 was 77%.

69% were immunized by the end of 1996.

Background and Strategies

In 1997, the Department launched a major initiative to increase the rate of fully immunized two-year-olds. In three years, we have jumped up 20 positions, going from 48th to 28th in national rankings. Now, over 75% of our two-year-old children have received their recommended vaccines. The Department successfully implemented the new daycare and school immunization requirements in the fall of 2001, vaccinating all school children against hepatitis A and hepatitis B and all daycare attendees against hemophilus influenza type b and chickenpox.

Division of Public Health

Measure

The percentage of families who are qualified for the services of the infant learning program who are enrolled in the program

Sec 81(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The target for the Early Intervention/Infant Learning Program (EI/ILP) is to eliminate the waitlist during FY2002 with funds provided by the legislature and ensure that 100% of eligible or qualified children and families are enrolled in the program. In FY2001, 1737 children were enrolled in the Infant Learning Program and there were 329 children on the waitlist (point-in-time on 6/30/01) for services for a total of 2066 eligible children. During FY2001, 76% of children qualified for services received EI/ILP services during each quarter of FY2001. On 6/30/01, 329 children remained on the waitlist for EI/ILP services.

This was a new measure for FY2000, therefore historical data have not been reported. During FY2000, 1626 children were enrolled in services and 307 were on the waitlist* (point-in-time on 6/30/00) for a total of 1933 eligible children. The average quarterly percentage of eligible children enrolled in EI/ILP services was approximately 72% during each quarter of FY2000. The percentage of qualified children who were enrolled in EI/ILP during each quarter of FY2001 increased approximately 4% from 72% in FY2000 to 76% for each quarter of FY2001.

Background and Strategies

Since FY1999, the three-year Early Intervention Enhancement and Improvement Opportunity (EIEIO) has enhanced the identification of rural children in need of EI/ILP services, increased services to enrolled children and families, and enhanced the infrastructure of the overall system in order to provide ongoing services to more children and families. A $700.0 GF/MH increment to eliminate the waitlist* became available for FY2002 and has been disbursed to EI/ILP grantees across the state.

*Waitlist = children who have been referred for screening, evaluation and/or enrollment in EI/ILP services and who have not been enrolled within 45 days of their initial referral and are still waiting for these services. Children eligible for Part C should never be waitlisted. Waitlist data are collected and reported point-in-time each quarter and should not be compared to cumulative enrollment during a fiscal year.

Division of Public Health

Measure

The rate of Tuberculosis cases by race and region

Sec 81(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The 2010 target is 6.8 cases per 100,000 population, which is the current baseline rate for the U.S. (1998).

Region	FY 2000 Rate per 100,000 Population	Cases
Anchorage/Mat-Su	11.7	37
Gulf Coast	6.8	5
Interior	7.1	7
Northern	76.3	18
Southeast	4.1	3
Southwest	98.8	38
TOTAL	**17.4**	**108**

The number of tuberculosis cases by race: Race for 108 cases – 11 white; 9 black; 71 Alaska Native; 17 Asian or Pacific Islander.

The average TB rate over the decade (1991-2000) was 12.5/100,000 population.

Background and Strategies

Tuberculosis has been a long-standing problem in Alaska and was the cause of death for 46% of all Alaskans who died in 1946. Major efforts, which included 10% of the entire state budget in 1946, led to one of the state's most visible public health successes-major reductions in TB across the state. Now this disease is reemerging and with it the threat of treatment resistant strains of the disease. Inadequate resources to monitor and educate those most at risk have resulted in continual outbreaks. Significant new resources are needed to do the case finding, diagnostic tests and treatment follow-up required to keep the disease in check.

Division of Public Health

Measure

The rate of child hospitalizations and fatalities related to injury

Sec 81(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The 2010 target is 9.9 injury fatalities per 100,000 0-19 year olds.

Rate of Injury of Children 0-19 *(rate per 100,000)*	1996	1999
Injury Fatalities	43	31.7
Non Fatal Injury Hospitalizations	499.4	534.8*

*82% unintentional injuries; 18% related to suicide attempts, assault or other intentional injury.

No comparable US rate is available. In 1999 the discharge rate for children under 15 years old was 379/100,000 for injury and poisoning hospitalizations.

Background and Strategies

The Alaska Trauma Registry and Vital Statistics systems provide information on deaths and hospitalizations related to injury to children. The data provide very useful information for evaluating and refining child and adolescent injury prevention strategies. They show that one third of injury deaths of children are due to "intentional" injuries while 16.5% of non-fatal injury hospitalizations are due to intentional injuries.

Efforts geared towards putting smoke alarms in every home, having children wear bike helmets, ensuring proper and continual use of car seats and other educational campaigns have likely reduced child fatalities due to injury. Reducing firearm and ATV injuries are potentially promising areas for saving lives and health care resources. Hospital costs alone for children's injuries in Alaska are estimated to exceed $10 million per year.

Division of Public Health

Measure

The rate of hepatitis C cases

Sec 81(b)(5) Ch 90 SLA 2001 (HB250)

Alaska's Target and Progress

No 2010 targets have been established, since reporting has not been in place long enough to determine a benchmark.

The number of hepatitis C cases in 2000 is 870 case reports from Labs. These tests reflect both newly infected and those who have been infected for some time but are being tested for the first time - so the numbers cannot be used to determine current infection rates.

Reports of positive hepatitis C laboratory tests:

Number of Positive Hepatitis C Laboratory Tests Reported

Year	Number of Positive Tests	Ak Population	# positive tests/100,000 population
1996*	245	605,212	40.5
1997	570	609,655	93.5
1998	1003	617,082	162.5
1999	1196	622,000	192.3
2000	870	626,932	138.8

** 1996 was 1st reporting year*

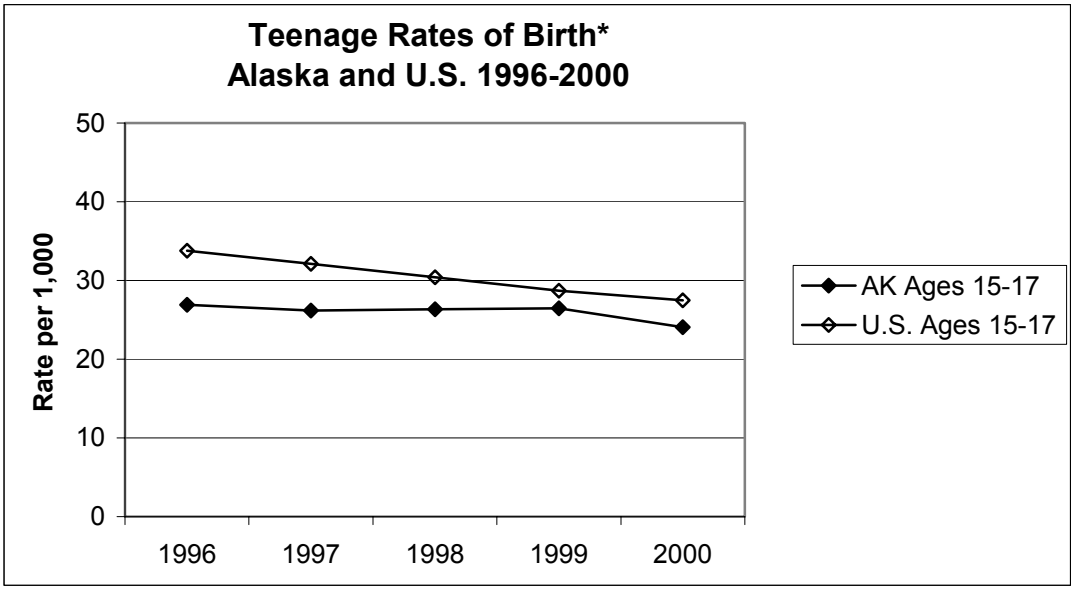
Measure

The rate of unmarried and married teen births.

Sec 81(b)(6) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The 2010 target for births to young teens is 18 per 1,000 girls ages 15-17. (Current Alaska rate is 24.1; U.S. rate is 27.5 in 2000)



Source: Alaska Bureau of Vital Statistics

•**Teen Birth Rates: Alaska and U.S., 1996-2000** From 1996 to 2000, the birth rate for Alaska females ages 15-17 fell by over 10 percent (from 26.9 in 1996 to 24.1 in 2000). Over the same period, the U.S. birth rate for females ages 15-17 fell by 18.6% (from 33.8 to 27.5).

•Although Alaska's birth rate for 15-17 year-old teens did not fall as steeply as the U.S. rate, it remained below the U.S. rate throughout the five-year period (1996-2000).

Background and Strategies

The teen birth rate in 1998 reached the Healthy Alaskans 2000 goal of fewer than 50 per 1,000 girls aged 15-19, down from 66.2 in 1990. Activities to educate on the risks associated with unmarried and teen child bearing, together with increased access to reliable contraception, may have influenced these numbers.

Division of Public Health

Measure

The rate of new cases of sexually transmitted diseases

Sec 81(b)(7) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

Implementation of a non-invasive mode of testing for Gonorrhea and Chlamydia has the potential to increase case finding, partner notification, and more timely follow-up.

1. Chlamydia: Reduce the chlamydia rate to 114 cases per 100,000 by FY 2010.

Year	Rate per 100,000
2000	413
1999	304

Based on current data, the 2001 rate will be higher than the 2000 rate.

2. Gonorrhea: Reduce the gonorrhea rate to 19 cases per 100,000 by FY 2010.

Year	Rate per 100,000
2000	58
1999	49

Based on current data, the 2001 rate will be higher than the 2000 rate.

3. HIV: Reduce the mean annual rate of new Alaska AIDS cases to fewer than 1.0 per 100,000 per year for the period from 2005-2010. The mean annual rate of Alaska AIDS cases diagnosed from 1996-2000 was 4.4 cases per 100,000 population.

Benchmark Comparison

The U.S. chlamydia rate in 2000 was 257.5 cases per 100,000 population. Chlamydia rates for 2000 in Washington, Oregon, Montana and Idaho were 227.0, 214.3, 166.4, and 152.4 per 1000,000, respectively.

The U.S. gonorrhea rate in 2000 was 131.6 cases per 100,000 population. Gonorrhea rates for 2000 in Washington, Oregon, Montana and Idaho were 42.0, 31.3, 6.8, and 7.8 per 100,000, respectively.

AIDS case rates for 2000 for the U.S. as a whole, Washington, and Oregon were 14.4, 8.7, and 6.1 cases per 100,000 population, respectively. Five-year mean annual AIDS case rates would be the most comparable measures for the low prevalence states of Idaho and Montana, but are not available.

Background and Strategies

Targeted screening and increased disease investigation activities have actually increased the total numbers of STD cases diagnosed. These activities effectively identify infected individuals with no symptoms and also identify and treat exposed individuals before they develop symptoms or further transmit infection. Case numbers are expected to decline over time as these activities reduce the reservoir of infected individuals in the population.

HIV disease investigation activities work with HIV-infected persons to notify their partners of their exposure to HIV and offer them HIV counseling and testing. A small number of individuals are newly diagnosed each year and assisted to access care. Uninfected individuals who have been exposed to HIV are counseled about preventing future infection

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Division of Alcohol and Drug Abuse

Mission

The mission of the Division of Alcoholism and Drug Abuse is to reduce alcoholism and substance abuse.

Division of Alcohol and Drug Abuse

Measure

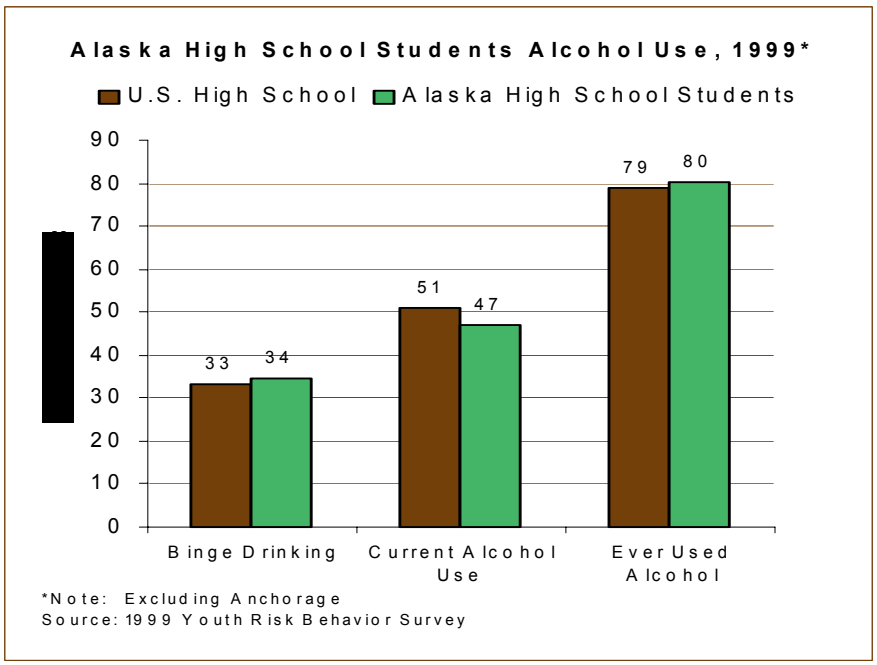
The rate of binge or chronic drinking by age group.

Sec 82(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

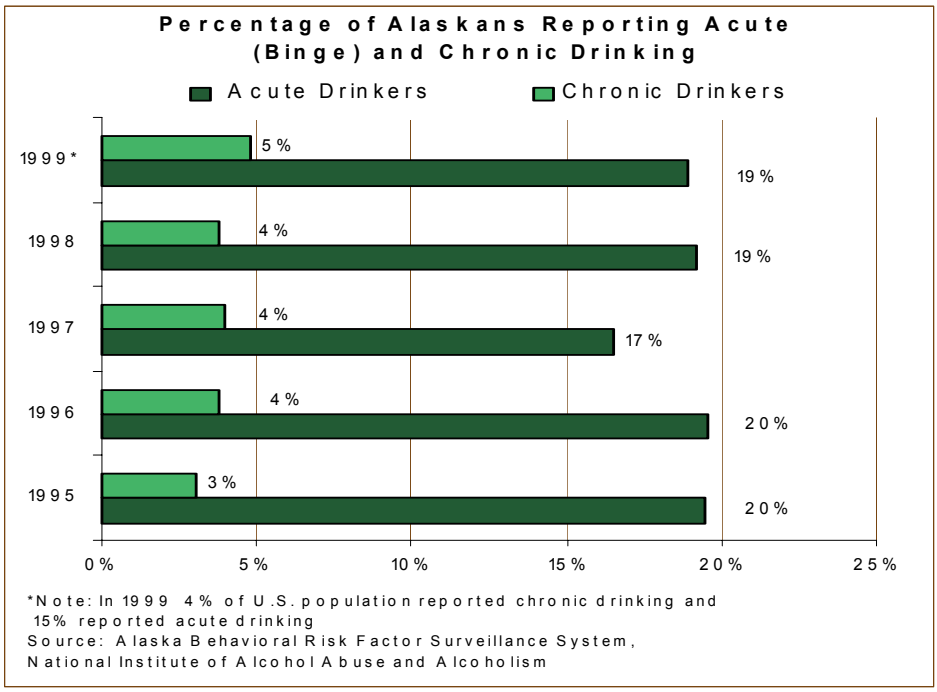
Healthy Alaskans 2010			
Substance Abuse	1999 Baseline	Target	
Increase Avg age of 1st use of alcohol	12.4	16.1	years old
Reduce binge drinking in grades 9-12	34%	30%	
Increase proportion grades 9-12 who do not use alcohol, marijuana or cocaine in the last 30 days	49%	60%	
Decrease the number of 9-12 graders who get in a vehicle with a driver who has been drinking	30%	20%	

The following charts show the drinking habits of Alaska adults (1995-1999) and youth (1999).



In 1999, according to Youth Risk Behavior Survey (YRBS) data, 46.9 % of high school students reported having had at least one drink of alcohol in the past 30 days. 34.4% reported at least one binge-drinking episode (five or more drinks in a row) in the past 30 days. (Anchorage students not included in the sample).

In 1995, according to YRBS data, 47.5% of high school students reported having had at least one drink of alcohol in the past 30 days. 31.3% reported at least one binge-drinking episode in the past 30 days. (Statewide sample)



In 1995 Alaskans reported 20% acute (binge) drinkers and 3% chronic drinkers in the Alaska Risk Behavior Factor Surveillance Survey.

Benchmark Comparison

US Baseline (1999)

- Reduce binge drinking among adults to 15%.

Increase the proportion of adolescents (grades 9-12) not using alcohol (or illicit drugs) during the past 30 days to 46%.

Background and Strategies

Binge drinking, for the purposes of this survey, refers to drinking five or mores drinks on one occasion, at least once in the month preceding the survey. Chronic drinking refers to drinking an average of sixty or more alcoholic drinks in the month preceding the survey.

There is a high correlation between these drinking patterns and many of the negative consequences associated with alcohol abuse, particularly medical, family, and employment problems. Excessive alcohol intake is related to 4 of the 10 leading causes of death in the United States.

The YRBS is the survey tool that provides information on this measure for youth. The new active parental consent law for surveys increased significantly the burden on local school districts. A sufficient and reliable sample of the state's high school students could not be identified during 2001 under the active parental consent requirement (no figures are available for Anchorage).

The measurement of alcohol use among high school students may not be possible in the future, until another method can be devised. Efforts to reduce youth drinking are on-going and varied.

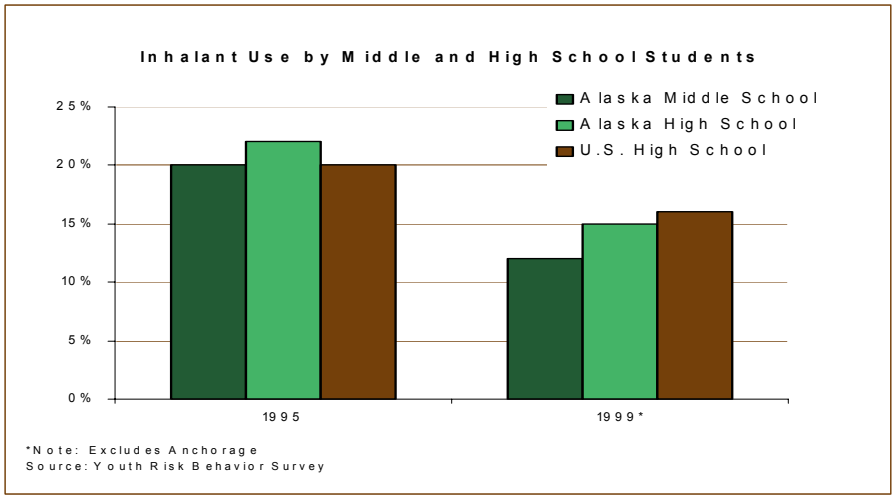
Division of Alcohol and Drug Abuse

Measure
The rate of drug and inhalant abuse by age group and region.

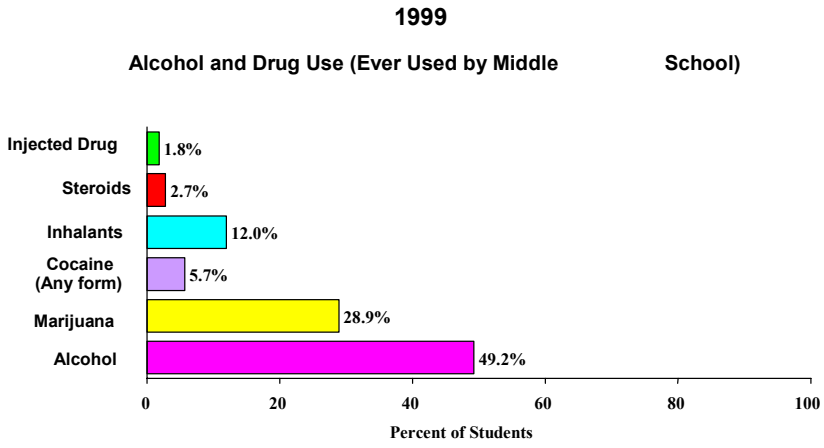
Sec 82(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

In 1995, 22% of Alaska high school students reported that they had sniffed an inhalant to get high. In 1999, this percentage had dropped to 15%. This change may be the result of Anchorage not being a part of the 1999 Youth Risk Behavior Survey and is not to be taken as an actual drop in abuse by teenagers. According to the 1999 National "Monitoring the Future" study, 19.7 percent of students will have used inhalants at least once in their lifetime.



Twenty-two percent have used an inhalant by the time they have reached the eighth grade. At least 49 percent of middle school students have experimented with at least one type of drug or alcohol.



Background and Strategies

Nationally, 29% of those who use inhalants said they started before their 10th birthday. Communities don't know that inhalants, cheap, legal and accessible products, are as popular among primary and middle school students as marijuana. Even fewer know the deadly effects the poisons in these products have on the brain and body when they are inhaled or "huffed." Inhalants can cause permanent damage to the brain, heart, kidneys and liver, and can cause death. It's like playing Russian roulette. The user can die the 1st, 10th or 100th time a product is misused as an inhalant.

The Alaskan teen usage information is collected through the Youth Risk Behavior Survey. The sample that is drawn is meant to be representative of the State and is not designed to be broken out by region. We use the sampling methodology set forth by CDC so that our data is comparable to National data. The whole sampling methodology would have to be changed and would also have to be a much larger sample if we were to have regional data, and the data would not be comparable to National data.

The local school districts have the opportunity to collect school district data and some districts have done that in the past. Unfortunately, the Department doesn't have access to that data unless the school district releases it to us.

Division of Alcohol and Drug Abuse

Measure

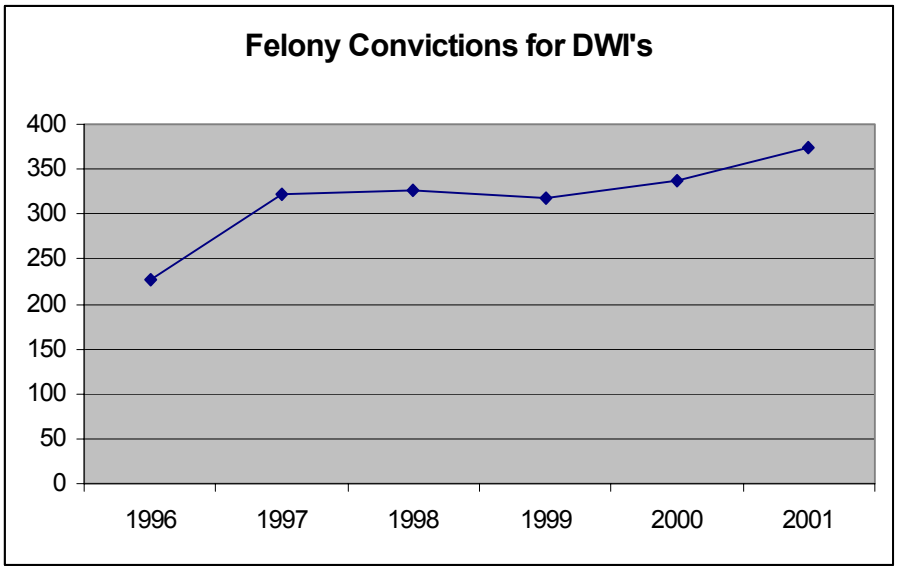
Number of new convictions and the number of repeat convictions in state district and superior courts on charges of driving while intoxicated (DWI).

Sec 82(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

Felony DWI Case Convictions

FY1996	FY1997	FY1998	FY1999	FY2000	FY2001
227	322	326	317	337	373



Background and Strategies

Driving while under the influence of alcohol (DWI) is one of the strongest indicators of the negative consequences associated with alcohol misuse. Recent DWI data shows that approximately 45 - 48 percent of all automobile accident fatalities had alcohol or drugs as the major contributing factor. Driving while under the influence of alcohol impacts lives, not only in accidents, injuries, and deaths, but also in family suffering, employment problems, and social functioning.

Division of Alcohol and Drug Abuse

Measure

Number and rate of infants affected by prenatal exposure to alcohol by region.

Sec 82(b)(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

In October 2001, the Fetal Alcohol Syndrome (FAS) Surveillance Project released new FAS prevalence data for Alaska. At this time, only statewide data is being released, due to the small amount of data for some regions which provides a skewed representation of the true picture.

At this time, the FAS prevalence rate for the state is 1.4 per 1,000 live births and 12.6 per 1,000 live births for those at risk for some type of alcohol-related birth defect. These rates are higher than previously reported rates, but they are more accurate due to the increase in our ability to track.

Beginning in June of 2000, newly developed and trained FAS Diagnostic Teams began providing FAS diagnostic services. During FY01, 121 completed FAS diagnoses were performed in our first six communities. It is our expectation that with these increased services, we will see an increase in the number of reports to the Birth Defects Registry. We are currently analyzing the FAS Team data that has been submitted and will have regular reports as new data is provided.

Nine children, who were born in 1990, have been reported to the birth defects registry that were diagnosed as having been prenatally exposed to alcohol or with microcephally or small head.

Because so much of this data is newly tracked and we are continuing to develop the most appropriate methodologies for tracking this disability, we may need to add additional benchmark data as we make progress in better understanding the complexities of an FASD diagnosis and the diagnostic process.

Background and Strategies

Since 1998, the DHSS Office of FAS and the FAS Surveillance Project have been working in collaboration to establish accurate and reliable data regarding the number and rate of infants affected by prenatal exposure to alcohol, statewide as well as regionally. Prior to 1996, the state had no systematic process for collecting data on children born prenatally exposed to alcohol. Prenatal exposure to alcohol became a reportable birth defect/condition in 1998 through the Alaska Birth Defects Registry (ABDR). Unlike all other birth defects that must be reported within the first year following birth, alcohol-related birth defects (ARBD) can be reported up through the age of six.

In addition to not having a system for tracking alcohol-related birth defects, until 1998 there were few options in the state for obtaining screening and

diagnostic services for individuals suspected to have fetal alcohol spectrum disorders (FASD). Since 2000, the state has increased diagnostic services across the state, at the community level with the expectation that we will begin to see an increase in reporting to the Birth Defects Registry. Alaska's 5-year FAS Project has a number of planned activities and projects that will continue to increase public and community awareness about the dangers of drinking alcohol during pregnancy, increase services to individuals and families affected by FASD, and improve our state's overall efforts to prevent FASD and to improve services to families already affected by disabilities associated with prenatal alcohol exposure.

Division of Alcohol and Drug Abuse

Measure

Number of new admissions as a percentage of the total admissions to treatment programs for alcohol and drug abuse.

Sec 82(b)(5) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

In FY2001, the rate of new admissions (2,020) to total admissions to treatment (5,828) was 34.66%.

In FY2000, the ratio of new admissions to the total admissions for treatment was 38.65%. 7,048 clients were admitted to substance abuse treatment as reported in the division's statewide Management Information System (MIS). Of the total admissions, 2,724 were identified as new* admissions.

*New admission means never before admitted to the treatment system in the history of the MIS, which began in 1983.

Background and Strategies

Below are a few of the outcomes derived from Alaska's Chemical Dependency Treatment Outcome Study:

* *Both residential and outpatient program participants reported substantial decreases in legal problems one year post treatment. Criminal arrests, traffic arrests and motor vehicle accidents dropped. This yields overall societal benefits as a result of chemical dependency treatment by easing demands on already overburdened legal and insurance systems.*

* *Of Alaskan patients surveyed, 56 percent of those in outpatient programs abstained from alcohol for one year after treatment, compared to 42 percent of residential patients. Outpatients in the study received an average of 59 hours of care, while patients in residential programs received an average of 39 days of inpatient care.*

* *Documented reductions in hospitalizations and emergency care and outpatient care for chemical dependency patients support the notion that, following treatment there is a shifting away from costly hospital and emergency room "crisis" or urgent care, toward more timely and appropriate preventive or routine outpatient treatment.*

* *Employment rates changed dramatically from pretreatment through one year after treatment. Full-time employment increased from 30 percent before treatment to 45 percent at 12 months. Conversely, unemployment rates dropped from 45 percent to 24 percent.*

It is important to note, however that Alcoholism is a chronic, progressive, but treatable disease. As in all chronic diseases, relapse is a part of the disease process. A client being readmitted to treatment after a period of time in remission is not uncommon. Relapse is defined as "to regress after partial recovery from an illness."

Division of Alcohol and Drug Abuse

Measure

Length of time that alcohol or other drug treatment clients are on waiting lists before receiving services.

Sec 82(b)(6) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The division is currently working with the grantees to provide the length of time that individual's are on a waitlist on a regular basis. As of July, 2001, the number of people on the wait-lists were:

Program	No. on Waitlist	Bed/Capacity Need
Women w/ Children	67	19
Adult Residential	123	40

The needed bed/capacity for women with children was calculated based on an average of 100 days in treatment. (365 days per year/100 days per woman for treatment = 3.65 women per bed in one year; 61 women currently on the waitlist/3.65 women per bed = 16.71 beds/year).

Currently the Division's wait list for adult residential programs stands at 123. In addition the DOC states that up to 120 persons per year are discharged needing dual diagnosis residential care. These persons may or may not be on the wait list. This waitlist does not distinguish between levels of care needed. Within this population there is need for short-term, long-term and dual diagnosis treatment.

Average length of stay are:

Women's programs: 42 days
Women and Children's Programs: 107 days
Adult Long term residential: 63 days
Dual Diagnosis: 43 days
Adult short term residential: 27 days

Background and Strategies

One of the most important aspects of successful treatment is that person enters the program when they are physically, mentally and emotionally ready. If they are placed on a waiting list, the chances are that they will not get the treatment they need. The result of being on a wait list is that they risk losing the motivation that triggered them to seek out a treatment program in the first place.

Division of Mental Health and Developmental Disabilities

Mission

The mission of the Division of Mental Health and Developmental Disabilities is to improve and enhance the quality of life for consumers impacted by mental disorders or developmental disabilities.

Measure

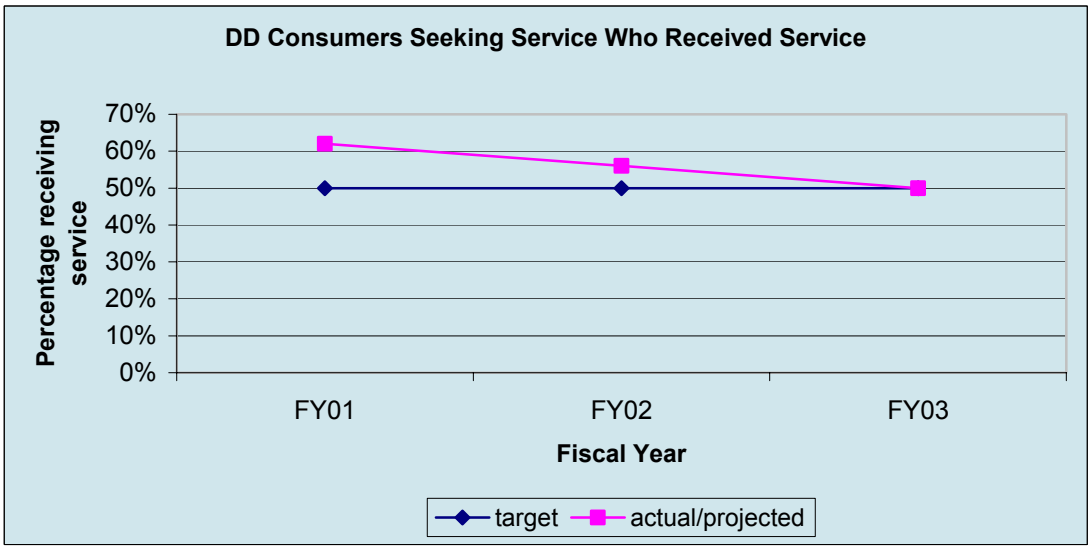
The percentage of those consumers who seek services for developmental disabilities who receive services at various levels from the division.

Sec 83(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The Developmental Disabilities (DD) Program target for the percentage of those consumers who seek services for developmental disabilities who receive services at various levels from the division is 50%. If the level of appropriation is maintained at its current amount and the waitlist continues to grow at its current pace, the percentage of consumers who seek services and who will receive services through grants will decline.

To receive funds under the DD program a person must be deemed eligible and be placed on the waitlist. By cross-referencing the waitlist with current program census information submitted by DD grantees, it was determined that 62% of the people on the waitlist in FY 01 received a service or support administered by DMHDD.



The performance measure represents those individuals who remain on the list while receiving services delivered by organizations across the state that receive DD Community Grants administered by the Division. Respite care, core services, or the purchase of special medical equipment are examples the type of assistance available to avert a crisis or delay the need for long-term care.

The measure does not relate to people who are selected and removed from the list to receive more comprehensive services. The measure also does not include individuals removed from the list as a result of obtaining comprehensive services or long-term care through Home and Community Based Waivers.

In prior years this data was collected as a raw total rather than a percentage. In FY00, 2,460 consumers received service through the program's grants and waivers, representing a 26% increase in one year. In FY99, 1,953 consumers received services through the program's grants and waivers.

Benchmark Comparison

No known Benchmarks or comparisons exist from other states or similar programs in Alaska. Of the 1,250 individuals on the waitlist as of September, only 251 were over the age of 22. Those younger than 22 are most likely receiving services through Infant Learning Programs (ages 0 – 3) or they are enrolled in special education (ages 3 – 22). While this may lessen the need for more comprehensive services, families report the need for additional supports to care for their children having DD. Also, it may represent good planning on the part of the family so their future needs can be considered.

Background and Strategies

The DD waitlist demographics and reasons for the growth in the waitlist are summarized in a waitlist report produced for the legislature each year on November 15. Basically, the waitlist grows as a function of improvements in medical technology and practice, population growth, and increased awareness of the benefits of DD services by families with young children. The capacity of provider organizations to deliver services to new people is limited by workforce shortages.

As the role of parents, particularly single parents, changes from being the child's primary care giver to becoming the sole source of income, the demand for paid supports to children with DD in the family expands. There are no readily-available institutional residences in Alaska for people with DD as there once were. Consequently, homes in the community must be developed before an individual can be placed with a provider. That process adds time for the person waiting for services.

Measure

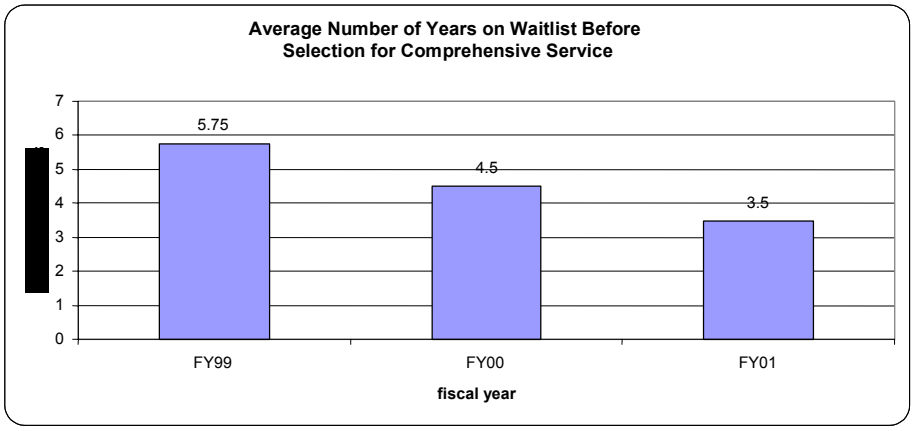
The average length of time that developmentally disabled consumers are on a waiting list before receiving full services.

Sec 83(b)(2) Ch 90 SLA 2001(HB 250)

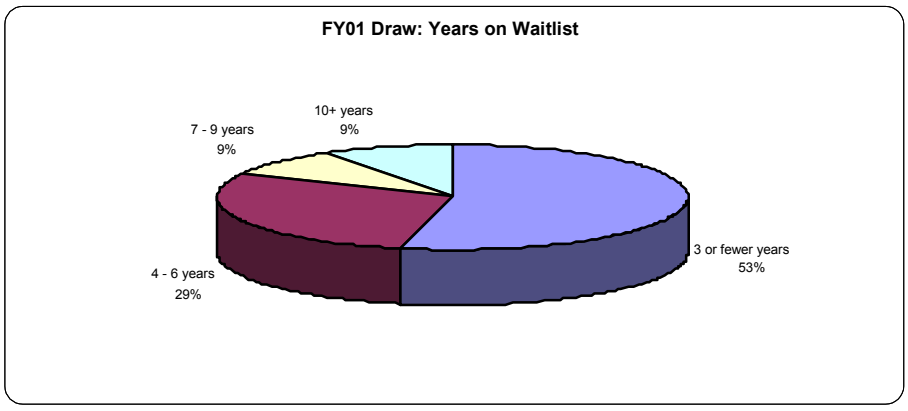
Alaska's Target and Progress

The target level for FY 03 for the average length of time that developmentally disabled consumers are on a waiting list before receiving full services is 4 years.

The waiting period in Alaska has been shrinking over the past 3 years, but that trend may not continue.



Of the 256 individuals removed from the waitlist to receive comprehensive or long-term care services in FY01, 53% had been on the list for less than 3 years.



Benchmark Comparison

Due to differences in the way states administer DD Programs and manage waiting lists, there are no known comparisons.

Background and Strategies

The length of time consumers remain on the waitlist is inversely proportionate to several factors: the growth of the Community DD Services budgetary appropriation, the increase in the number of Home and Community Based Waivers, and further development of service provider capacity. Without these increases, and due to the escalating number of consumers being added to the Waitlist, the average time before someone is selected for services will increase.

Measure

The percentage of mental health consumers receiving services who show improved functioning as a result of the services.

Sec 83(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

There tends to be a difference in the rate at which children and adult mental health consumers improve as a result of receiving services. Early intervention does seem to have a greater impact. Alaska's targets are 20% for adults and 25% for children.

Based on aggregate data submissions for FY00 and FY01 by community mental health centers, we are achieving an improvement rate greater than expected:

MH Consumer Improvement

	total served	% improved
FY00 - Adults	10,110	40%
FY01 - Adults	10,507	38%
FY00 - Children	6,355	46%
FY01 - Children	6,396	53%

The Division collaborated with a University of Alaska Anchorage research team to develop several surveys that mental health clinicians could use with their patients. These tolls measure a mental health consumer's functional level and can be used to make a comparison across time.

Background and Strategies

Given the serious nature of chronic mental illness, only limited sustained functional improvement can be expected. The focus of mental health treatment for consumers with the most severe challenge is to maintain their current level of functioning and to avoid the need for inpatient treatment.

The Division anticipates revising our targets for children and adult population as we move towards collecting individual service data, from which we can more accurately determine trend lines.

Division of Mental Health and Developmental Disabilities

Measure

The percentage of programs designated by the department that are reviewed for consumer satisfaction.

Sec 83(b)(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The Division's target is to achieve and maintain at least a 50% annual review rate for agencies receiving grants through the division for direct client care.

In FY01, 41% of mental health service programs and 46% of developmental disabilities service programs were reviewed for consumer satisfaction. This contrasts with the FY99 data during which 49% of mental health programs and 34% of developmental disabilities programs were reviewed.

Background and Strategies

The target of reviewing 50% of the designated programs for in FY01 was not met due to the manner programs are identified for review each year. Integrated QA reviews occur in a two-year cycle. For the FY01 and 02 cycle there were a total of 44 programs selected for review. Twenty of these were selected for FY01 while 24 programs were selected for review in FY02. During FY01 one program was closed prior to the review being conducted and another was not reviewed due to their location (Aleutians) in relation to the cost associated with conducting an on-site review. This left 18 programs that were successfully reviewed. The most obvious choices for improvement are to 1) reduce the goal from 50% to a lower, more achievable goal or 2) calculate the number of programs in a manner that excludes those that weren't reviewed if a review was impossible or impractical.

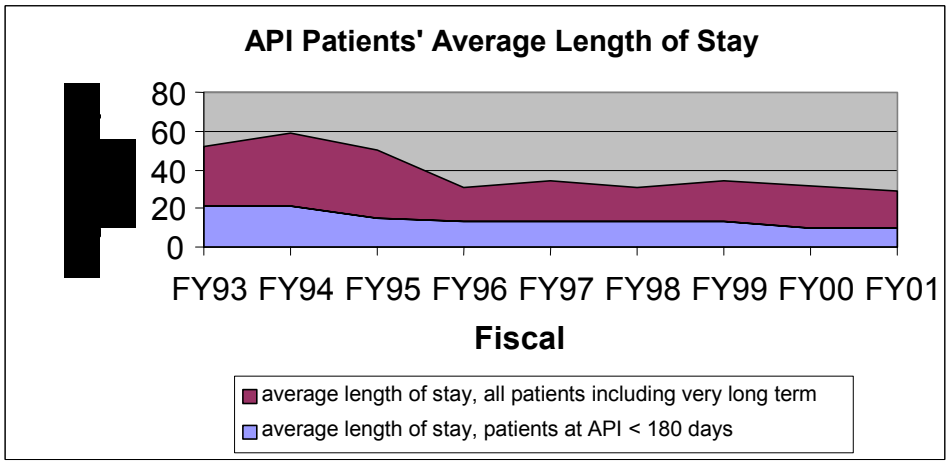
Measure

The average length of stay at the Alaska Psychiatric Institute.

Sec 83(b)(5) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

Significant data has been compiled on API over the past few years as a part of the evaluation of the federally-funded Community Mental Health/API Replacement Project. As a result, it has become clear that community mental health providers would prefer that API be able to retain patients experiencing chronic mental illnesses for longer periods of time, so that the patients were more adequately or fully stabilized prior to their discharge back to their community and the community mental health center (CMHC) program with which they are associated. These providers would clearly prefer an average length of stay (ALOS) of more than 10 days.



API's ALOS for FY01 was 10 days for persons at API with stays of 180 days of less. When you include all persons being treated at API, (including those with stays in excess of 180 days) the ALOS rises to 19 days. Since the number of persons at API with stays over 180 days totaled just 34, so it is clear that an ALOS of 10 days applies to the vast majority of the 1,544 patients admitted to API in FY01.

In FY01, API length of stay (LOS) data shows the following:

29% of all persons admitted were discharged from API within 1 day.
21% were discharged within two or three days
22% were discharged within four to 12 days
18% were discharged within 13 to 30 days
7% were discharged within 31 to 60 days
3% were discharged after 60 days.

Thus, 50% of all persons admitted to API were discharged within 3 days,

many of whom were first-time admits with substance abuse as well as acute psychiatric concerns at the time of admission.

Another 22% were discharged within 12 days. Hospitalizations of under two weeks are viewed as inadequate for some patients with chronic mental illnesses. From a CMHC's perspective, shorts stays not only fail to provide sufficient treatment time but also do not allow for adequate discharge planning between API, the patient, and the community provider.

While the State has not yet identified a specific target ALOS, given the comments of community mental health providers, it is clear that a goal of more than 10 days may be appropriate.

The increase in local capacity outside of Anchorage and the development of the Single Point of Entry in Anchorage at Providence Hospital will contribute to API's movement towards its goal of becoming a more tertiary care facility.

Benchmark Comparison

Good data on lengths of stay at other public psychiatric hospitals across the country does not exist. While a national database containing such data is presently under development through the auspices of the National Association of State Mental Health Program Director's Research Institute (NRI), NRI has not produced ALOS data for State psychiatric hospitals. The vast majority of public psychiatric hospitals in the nation are reporting a variety of performance measurement data to NRI, but lengths of stay is not yet one of the performance areas that the NRI is measuring.

Finally, API's very short ALOS is highly unusual for a state psychiatric hospital. The majority of public psychiatric hospitals do not accept emergency admissions, as API does

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Office of the Commissioner

Mission

The mission of the Office of the Commissioner is to
provide support and policy direction to the divisions within the department.

Office of the Commissioner

Measure

The percentage of divisions within the department that meet assigned performance measures.

Sec 84(b)(1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

The Department of Health and Social Services has eight divisions which track and report on 48 legislatively assigned performance measures.

All divisions have reported on their assigned measures and continue to work toward meeting established targets and goals.

For newer measures, divisions continue to work on setting a target or goal.

Office of the Commissioner

Measure

The average time taken to respond to complaints and questions that have been elevated to the Commissioner's Office.

Sec 84(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

In FY2001, there were 126 questions and complaints logged into the Commissioner's Office Correspondence Tracking System. The average time to respond to these inquiries was 11 working days.

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Division of Administrative Services

Mission

The mission of the Division of Administrative Services is
to provide quality administrative services that support the department's programs.

Division of Administrative Services

Measure

The cost of Administrative Services personnel as compared to the cost of the entire Department's personnel.

Sec 85(b)1) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

	ADMIN SVCS/ COMM OFFICE	TOTAL DEPARTMENT	PERCENTAGE
FY00	$5,207.2	$121,253.9	4.29%
FY01	$5,855.3	$128,541.7	4.34%

Background and Strategies

Total costs (includes non-GF) associated with the Division of Administrative Services and the Commissioners Office are included in totals.

Division of Administrative Services

Measure

The percentage of grievances and complaints resolved without resort to arbitration.

Sec 85(b)(2) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

In FY 2000 there were 131 cases and 98% were resolved without arbitration.

In FY 2001 there were 74 cases and 97% were resolved without arbitration.

Background and Strategies

The number of cases declined from FY2000 to FY2001. This is partly due to the DHSS training that has been given to all supervisors.

Division of Administrative Services

Measure

The average number of days taken for vendor payments.

Sec 85(b)(3) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress

FY2000 = 34 days
FY2001 = 33 days

Background and Strategies

It is important to note that the average payment days extracted from the accounting system start with the vendor's date listed on invoice. Therefore, the report extracted from the accounting system does not accurately reflect the days it takes a department fiscal office to process a vendor invoice.

Division of Administrative Services

Measure

The percentage of audit exceptions that are resolved.

Sec 85(b)(4) Ch 90 SLA 2001(HB 250)

Alaska's Target and Progress	In FY2000 a total of 6 audit exceptions occurred, all of which will be resolved by 6/30/2002.
Background and Strategies	The State Single Audits are one year behind. The data collected here will be one year later than other targets.

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INITIATIVES

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Alcohol Abuse & Alcoholism in Alaska

Alcohol is the most significant contributing factor to crime in Alaska. Alcohol is also the number one public health issue facing Alaska. Excessive drinking is associated with child abuse, domestic violence, and low educational achievement in our state. The FY2003 budget for the Alcohol and Drug Abuse BRU proposes $8.3 million GF to address problems related to alcohol abuse and alcoholism.

'Alaska leads the nation in alcohol abuse. Statistics show that eighty percent of all crimes are committed by individuals under the influence of alcohol or drugs.'

--Ted Stevens
U.S. Senator

~

Alaska ranks first among all states in alcohol mortality. The prevalence of alcohol dependence and alcohol abuse in Alaska is almost twice the national average.

~

Nationwide, Alaska has the 5th in the nation for severity of alcohol-related problems, but ranks 32nd for treatment services provided per capita.

~

Enough alcohol was sold in Alaska in FY99 to add up to 516 drinks for every man, woman and child.

What does alcohol abuse and alcoholism cost our state?

Alcoholism is epidemic in Alaska. Historically and currently, the abuse of alcohol is pervasive within our communities and families. Putting a price tag on the impacts of alcohol abuse and alcoholism is extremely difficult. According to a study recently completed by McDowell Group, Inc. for the Advisory Board on Alcoholism and Drug Abuse, the cost of alcohol and other drug dependency on the Alaska economy was estimated to be $614 million during 1999. Alcohol abuse costs accounted for $453 million, or 74% of that total. Cost by category includes:

- $319 million from productivity losses
- $146 million from criminal justice and protective services
- $123 million from health care
- $21 million from traffic crashes
- $4 million from public assistance

Alcohol Treatment Waitlists

Waiting lists are only one measure of the general need for alcoholism treatment services. Waiting lists could be characterized as representing those persons most highly motivated to seek treatment.

The calendar year 2000 waiting lists for alcohol treatment included: 61 women with children, 143 needing adult residential treatment, and 140 needing adult outpatient treatment. It is estimated that of the adult residential treatment need, 57 would be short term care, 29 would be long term care, and 57 would require dual diagnosis treatment for those with both substance abuse and mental health diagnoses. An additional 18 are estimated (but not on a waitlist) to need dual diagnosis treatment after discharge by the Department of Corrections.

Elimination of the waiting lists is a good first step, but it would not allow the State to provide treatment to everyone who needs it and who would accept if it were immediately available.

Does treatment work?

Alcoholism is a chronic, progressive, disease. It is treatable. Many people relapse several times before achieving long-term sobriety. But a

recent study examining the effectiveness of publicly funded treatment programs in Alaska found that 56 percent of outpatient clients and 42 percent of residential clients abstained from alcohol for one year after treatment. The study found a strong association between abstinence and participation in follow-up care and peer support groups such as alcoholics anonymous.

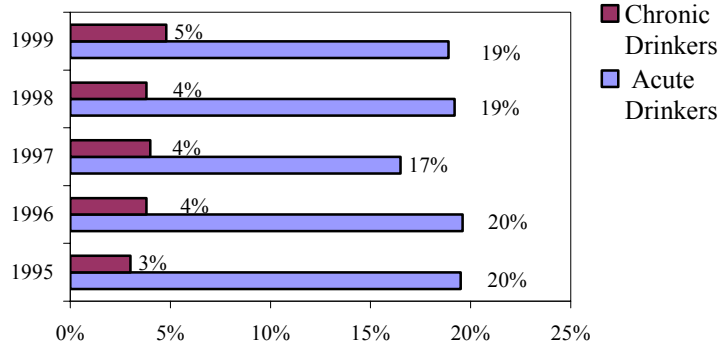
The study also found that, among participants:

- Arrests and motor vehicle accidents decreased;
- Full-time employment increased from 30 percent to 45 percent;
- Unemployment rates dropped from 45 percent to 24 percent;
- Visits to hospital emergency rooms declined.

An indication of the pervasiveness of alcohol abuse is the percentage of Alaskans who report acute (binge) and chronic drinking. In 1999, 19% of Alaskan adults reported binge drinking compared with 15% nationwide.

Alcohol consumption rates illustrate the extent of alcohol-related problems. Alaska has the second highest rate of alcohol consumption in the nation, behind Wisconsin.

Percentage of Alaskans Reporting Acute (Binge) and Chronic Drinking



Source: Alaska Behavioral Risk Factor Surveillance System, National Institute of Alcohol Abuse and Alcoholism

What should be done?

1. Increase availability of substance abuse treatment for adults by increasing the number of beds at existing residential facilities for both short term and long term care as well as increasing the availability of dual diagnosis treatment for those individuals with both a substance abuse and a mental health diagnosis. ($471.8 GF, $1442.6 GF/MH);

2. Increase treatment in rural Alaska by placing approximately 18 additional professionals trained in mental health and substance abuse counseling in rural communities; providing a minimum level of funding for small community outpatient treatment programs and increasing the funding for transitional housing for substance abusers leaving out-of-town treatment programs ($1,062.0 GF; $1,117.7 GF/MH; $300.0 MHTAAR);

3. Restore the successful Alcohol Safety Action Program to provide more substance abuse screening and monitoring of court-ordered treatment, including drunk drivers ($470.0 GF);

4. Maintain existing funding for Mental Health Trust programs for Women and Children alcohol programs by replacing MHTAAR funding which is transitioned to GF/MH ($300.0 GF/MH, -$300.0 MHTAAR);

5. There are additional alcohol treatment, inhalant abuse prevention and suicide prevention increments that are part of the Children's Health Initiative as well as a fund change from Federal to GF for existing Detox and Dual Diagnosis treatment in Anchorage and annualization costs included in the department's Maintain Services analysis.

Caring for Alaska's Neediest Citizens

Adult Public Assistance Program needs increase

'Our great state must continue to provide for our most vulnerable citizens.'
--Jim Nordlund
Director of Public Assistance

~

Adult Public Assistance (APA) was created to supplement Social Security disability benefits and provides the recipient with the income support needed to remain as independent as possible in the community.

~

In FY01, APA provided financial assistance and access to medical care for 4,661 elderly and 9,250 disabled Alaskans.

~

The APA population is expected to continue to grow at 4.2% from 14,551 in FY2002 to 15,156 in FY2003.

~

DPA participates in the federally funded Alaska Works Project, a five-year initiative designed to address the major barriers that keep people with disabilities from success in the workplace.

A Program for Needy Elderly, Blind and Disabled Alaskans

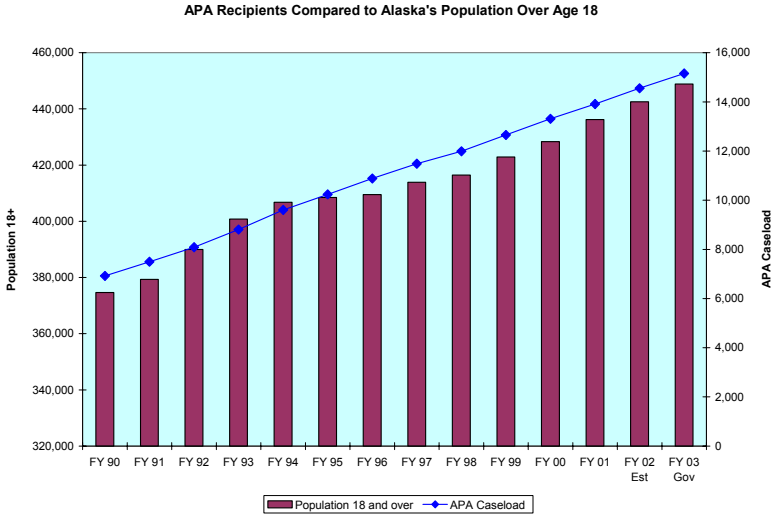
The Adult Public Assistance (APA) program provides basic living support to needy elderly, blind and disabled Alaskans. In FY03, APA is estimated to provide financial assistance and access to medical care for 4,924 elderly and 10,232 disabled Alaskans. The program was created to supplement Social Security disability benefits and provides the recipient with the income support needed to remain as independent as possible in the community.

To be eligible for APA, a low-income individual must be over 64 or at least 18 years of age, blind, or diagnosed by a physician as permanently disabled, chronically ill, or terminally ill. Applicants must also undergo a rigorous process to determine that their mental or physical limitations make them temporarily or permanently incapable of self-support through gainful employment. APA benefits help many Alaskans avert problems such as homelessness and avoid higher cost settings such as hospitals, nursing homes or incarceration.

APA Increment needed

The number of elderly and disabled Alaskans who rely on the APA program to meet basic needs has steadily increased – a trend that is expected to continue. The FY02 budget funds an APA population increase of 3%, but we expect a caseload increase of about 4.6% in FY02 and 4.2% in FY03. The total FY2003 formula increment is comprised of the FY2002 supplemental need and the projected formula increase for FY2003 caseload growth for a total request of $2.5 million.

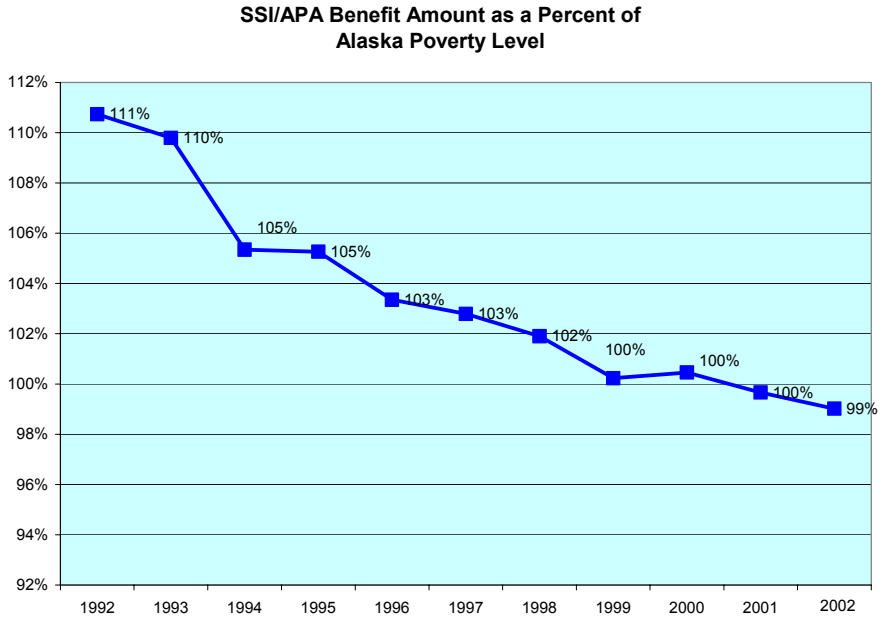
The reasons for this growth appear to be a combination of increased state population (as the chart shows), improved medical technology and an aging "baby boom" cohort. Growth in this program is sustained in part by the long-term needs of recipients



- to qualify for APA benefits, an individual must be elderly or have a permanent disability, and therefore this population tends to need to rely on the APA program for the remainder of their adult lives. Continued APA funding provides critical assistance as the program of last resort for this population.

Benefit Value Eroding

Cash benefits assist low income elderly and disabled individuals with their most basic necessities: shelter, clothing, transportation and food. Until a change in state law in 1993, Alaska's APA benefit level tracked the federal poverty level under a cost of living adjustment each year. Since that time the buying power of the state APA (and federal SSI) benefit has eroded to 99% of the federal poverty level, as shown on the graph.



Helping Disabled Alaskans Who Can Work

Within the APA population there are also individuals who, despite their disability, would like to work. However, lack of workplace accommodations, financial disincentives, and most notably, fear of the loss of Medicaid act as barriers to the goal of employment. Alaska has begun to address this problem by implementing the Working Disabled Medicaid option, which allows individuals whose earnings make them ineligible for traditional Medicaid to "buy-in" to the program by paying a premium. With this option many APA recipients can work, continue to receive critical health care, and contribute to their self-support.

The federal government has also addressed these issues with the passage of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). The Act established three grant programs designed to improve the capacity of State systems to support employment for people with disabilities. Alaska received these grants during FY 2001, a portion of which is being used to enhance services to APA recipients who wish to work. Four new positions have been established for the APA program to promote employment and self-sufficiency.

DPA also continues to participate in the federally funded Alaska Works Project, a five-year initiative designed to address the major barriers that keep people with disabilities from success in the workplace. Working collaboratively with the Governor's Council on Disabilities and Special Education and a consortium of state service providers, the project has begun to establish a coordinated and innovative service delivery system, and to eliminate barriers that prevent Alaskans with physical and mental disabilities from becoming competitively employed.

Homeland Security

Homeland Security is Governor Knowles' initiative to increase Alaska's security and preparedness against possible terrorist attacks. For the Department of Health and Social Services, this means expanding Public Health's ability to detect and respond to biological and chemical terrorism, improve communications between health agencies and providers, and better train and equip first responders. The FY2002-2003 Homeland Security bill proposes $3.6 million GF operating funds for the Division of Public Health.

The greatest national shortages in capabilities and resources to respond and react to Weapons of Mass Destruction events are in the areas of public health and medical response. Alaska is no exception to these shortages.

-- State of Alaska Terrorism Disaster Policy Cabinet Executive Summary

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Preparedness efforts by public health agencies to detect and respond to biological and chemical terrorism will have the added benefit of strengthening the U.S. capacity for identifying and controlling injuries and emerging infectious diseases. (CDC)

~

The tragic events of September require immediate attention to preparedness against terrorism and weapons of mass destruction at all levels of government.

Why does Public Health need support?

- ***Bioterrorism is a significant public health threat facing the United States.***
- ***Response to terrorist attack will require rapid deployment of scarce public health resources.***
- ***The nation and Alaska's public health infrastructure currently is not adequate to detect and respond to a terrorist event.***

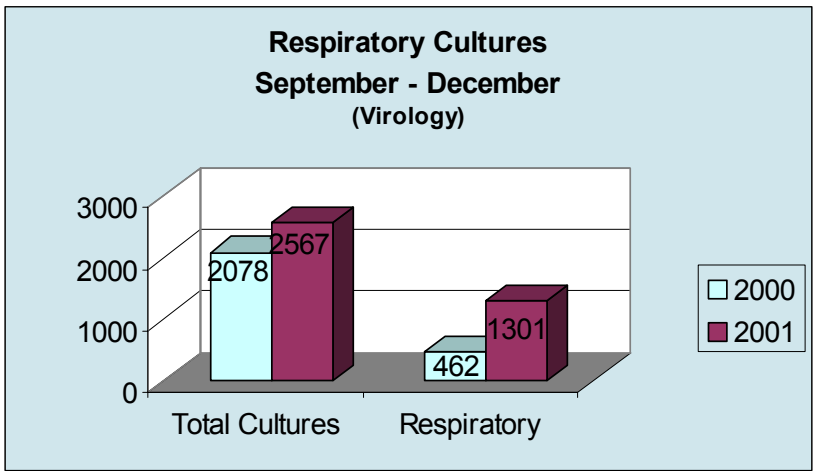
To deal with a mass casualty event, Alaska must make an increase in public health and medical capabilities, and the ability to deploy these resources, very high priorities. Because the initial detection of a covert biological or chemical attack will probably occur at the local level, disease surveillance systems at every level must be capable of detecting unusual patterns of disease or injury, including those caused by unusual or unknown threat agents. Epidemiologists must have expertise and the needed resources for responding to reports of clusters of rare, unusual, or unexplained illnesses. ("Biological and Chemical Terrorism: Strategic Plan for Preparedness and Response", US DHHS, Center for Disease Control and Prevention)

- ***Terrorism preparedness activities will improve our ability to investigate rapidly and control public health threats as they emerge in the twenty first century.***

Capacity and tools developed to respond to terrorist threats serve a dual purpose. The epidemiologic skills, surveillance methods, diagnostic techniques, and other resources required to detect and investigate unusual diseases, as well as syndromes or illness caused by common disease agents, are many of the same ones needed to identify and respond to an attack with a biological, radiological or chemical agent.

Thinking of disease control as an element of homeland security may be a new concept for some. However, recent national events tell us that deliberately introduced disease organisms can be just as deadly as other disasters. Investing in a solid frontline public health workforce is an essential defense for Alaska.

There has been a marked increase in the demand for services that are both directly and indirectly related to bioterrorism since September 11. The number and cost of respiratory cultures performed this fall was 2.8 times higher than the same period in 2000. Symptoms of most bioterrorism agents initially resemble common disease, and failure to differentiate common illness from a bioterrorist event will have dire consequences on the Alaska population.



What should be done?

***Homeland Security* in Public Health has four interdependent parts:**

- **Public Health Nursing:** Some of the remaining Back to Basics request to assure both an immediate response to bioterrorism or other terrorist event and ongoing management of outbreaks of infectious diseases; Bioterrorism preparedness to ensure that PHN staff are continually updated and trained to respond to a bioterrorism event or threat; and computer support to sustain secure, reliable communication systems for public health centers ($734.2).

- **Epidemiology:** The remaining Back to Basics funding to provide expert medical direction and oversight to field nurses and private providers relative to disease control and for overall outbreak management; staff and support for epidemiology to ensure expertise in detecting and responding to both bioterrorism and chemical terrorism events/threats to guide response in the event of an attack; public health pharmacist for oversight of all aspects of drug use and distribution; and contracted medical expertise to provide additional physician capacity in an emergency ($842.8).

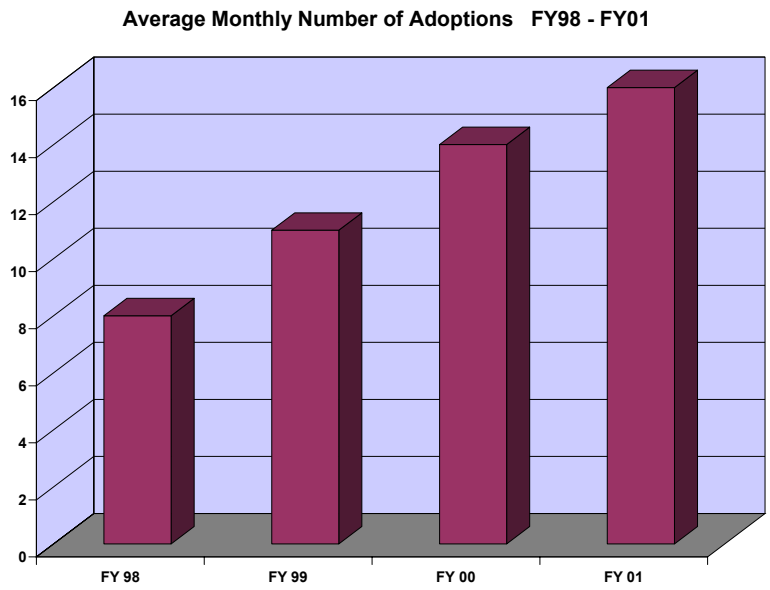
- **Community Health/ Emergency Medical Services and EMS Grants**: Disaster communications specialist and technical support to oversee a coordinated telecommunications system which is essential to rapid electronic communications among agencies and individuals responsible for responding to disasters and public health emergencies ($268.5). Grant funding to assist the regional EMS grantees to provide necessary special training and technical assistance in the areas of bioterrorism response, mass casualty response and responder safety ($330.0).

- **Public Health Laboratories:** Bioterrorism capacity for the Public Health Labs requires funding to provide full staffing; lab testing supplies and equipment needed for a sudden influx of test requests; 2 additional microbiologists to provide virology and bacteriology expertise at both the Anchorage and Fairbanks labs to ensure uninterrupted essential medical laboratory services if one of the labs becomes unavailable as the result of a terrorist event; and computer support essential for communications during a disaster or attack as well as for ongoing public health needs ($1,184.5). There is also a request for Back to Basics to conduct screening tests, confirm diagnoses and find sources of disease, including doing more tests due to the higher level of awareness and concern about infectious diseases related to possible bioterrorism ($240.0). This request is of even greater importance since September 11 because the skills and capacity needed to combat usual infectious diseases are essential to combat a terrorism attack using an infectious agent.

Maintain Services – Finish What We've Started

Child protection –

Balloon Project: Children that have been removed from their homes must not remain in state custody any longer than is necessary to ensure their safety. The Balloon Project has succeeded in finding permanent homes for 1,205 of the 1,630 targeted children as of December 15, 2001. $1,628.4 in general funds is requested to continue the work of the Balloon Project in FY 2003 through the Adoption Placement Program, which will provide the resources needed to achieve permanent placements for children.



Transcription Services: The Department of Health and Social Services requests $450.0 in general funds to fully implement the successful transcription service pilot project. Transcription services enable social workers to spend more of their time with children, parents, and foster parents while continuing to maintain up-to-date, accurate case files without additional clerical support.

DFYS Lease Space: Child protection workers in the Anchorage and Mat/Su field offices are currently located in inadequate space that compromises client confidentiality requirements and worker safety. $110.0 in federal receipts and $440.0 in general funds are requested to provide funding for the increased cost of leasing adequate office space.

Public Health –

Environment Food Safety: The DHSS requests $200.0 in general funds to establish a program that will provide consistent, scientifically credible information about food safety for recreational and subsistence food harvesters in Alaska. The presence of environmental contaminants in locally harvested foods is a threat to public health and a major issue for consumers.

Newborn Screening: The Maternal, Child and Family Health section conducts newborn metabolic screening and specialty clinics for children who cannot otherwise access these services. The MCFH section bills third party payers to recover as much of the cost of providing services as possible. This request of $100.0 in general fund program receipt authority will enable the MCFH section to fully utilize the funds generated through the billing process to offset the cost of providing services.

Alcohol and Drug Abuse Services –

Annualize Therapeutic Courts: Therapeutic courts for alcohol and drug-addicted offenders are expected to contribute to the long-term sobriety of offenders, help protect society from alcohol and drug related crime, encourage prompt payment of restitution to victims, and result in long-term reduction in the costs of arrest, trial, and incarceration of offenders. This request of $286.4 in general funds will provide full-year funding for continuation of the recently established pilot therapeutic courts in Anchorage and Bethel.

Maintain Anchorage Detox Beds: Maintain Anchorage Detox and Dual Diagnosis Alcohol Treatment Services: Enhanced detoxification and residential dual diagnosis treatment are two of the primary services provided in the Anchorage area under the Community Health/API Replacement project. Federal funds used for these services will no longer be available in FY 2003 and $1,078.5 in general fund/mental health funds is requested to maintain this critical service.

Facility cost annualization –

The Ketchikan Regional Youth Facility is expected to open in mid-FY 2002 and be fully operational for the entire year in FY 2003. The KRYF provides secure detention services for up to six residents and assessment/stabilization services for up to four mental health residents. The legislature appropriated funding for ten months of operation in FY 2002, this request of $110.1 in general funds will provide the funds needed for two additional months of operation at this 24 hour per day, seven day a week facility.

The Bethel Public Health Center is squeezed into a small, substandard building lying in a major floodplain. These serious deficiencies negatively impact the quality of care delivered to residents of the 58 villages in the Y-K delta. 25 itinerants, nurses and support staff are located in about 3600 square feet. The current building does not meet ADA, NFPA, or IBC standards nor does it comply with Federal EPA water quality standards. This request of $259.2 in general funds and $226.8 in interagency receipts, combined with funding appropriated by the legislature in FY 02 will provide for built-to-suit leased space that will enable the Bethel Public Health Center to meet the needs of the public.

Medical Assistance

Maintain access to health care and to provide health coverage for Alaskans in need.

Medicaid provided access to health care to approximately 118,000 Alaskans in FY 2001.

Alaska's largest Medicaid population is our children. On average, children are the least expensive Medicaid recipients.

Medicaid expenditures have increased an average of 17 percent per year from FY 1999 through FY 2001.

General fund expenditures per Medicaid eligible have decreased by $97 since FY 1999. During that same time period, other fund expenditure per eligible have increased by $856

"State Medicaid programs serve as an important safety net for Americans by providing health and long-term care coverage. Reduced state revenues are placing severe strains on many state budgets and could limit Medicaid at a time when additional coverage and spending is most needed."

-- The Kaiser Commission on Medicaid and the Uninsured, Medicaid and State Budgets: An October 2001 Update,

October 16, 2001.

The National Conference of State Legislatures, State Fiscal Outlook for FY2002 November Update, December 3, 2001, reports 23 of 51 states that specifically note Medicaid as a "Program Over Budget."

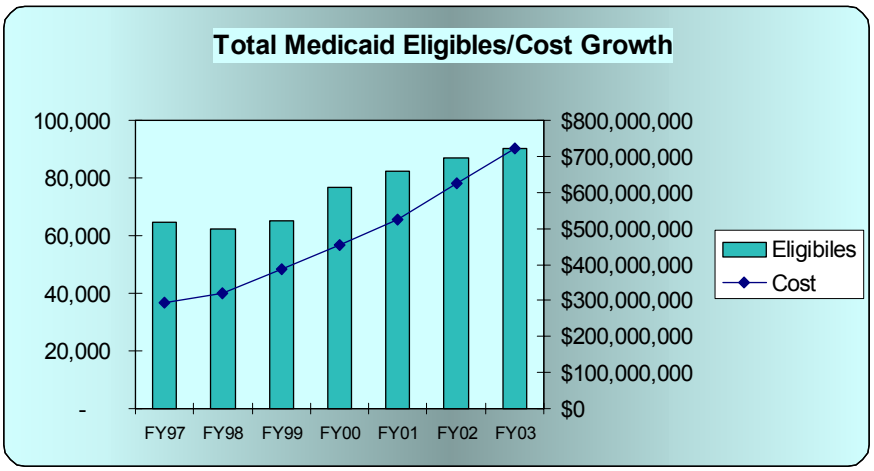
Medicaid –

Medicaid is a means-tested, jointly-funded cooperative effort between federal and state governments that provides health care coverage to persons in need. There are 56 individual Medicaid programs – each state, territory and district determines its own eligibility standards, benefits package, and payment rates within federal guidelines.

Alaska's Medicaid program currently provides medical care coverage to approximately 118,000 Alaskans. Persons eligible to receive benefits include children, caretakers of children, pregnant women, the aged, the blind, and the disabled of low-income that meet certain resource standards. Medicaid does not provide assistance to all low-income persons.

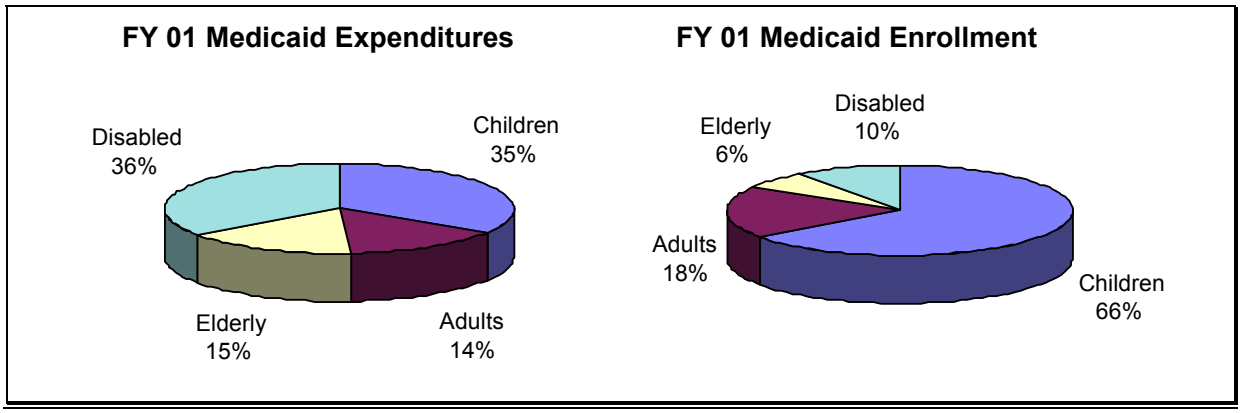
Medicaid continues to grow

In FY 2001, Medicaid enrollment increased by about 7,000 people, or 6 percent, over FY 2000. Medical services provided to recipients in FY 2001 cost $525.7 million – a 13 percent increase over FY 2000. Medicaid's claims payment rate of growth has averaged 17 percent since FY 1999.



The following chart shows eligible and expenditure percentages for the four Medicaid eligibility groups: children, adults, elderly and disabled.

The disabled group in each chart includes children (1.5 percent of the eligible numbers and 6 percent of the expenditures).



The following charts set out Medicaid program categories of service expenditures – what costs the most, what is growing the fastest.

FY01 Top Expenditure Categories of Services	
Hospital Services	$128,929,284
Physician Services	$96,600,954
Pharmacy	$54,973,432
Nursing Homes	$46,975,802
MRDD Waivers*	$42,377,562
Mental Health	$39,479,765
Medicaid Other Services	$28,551,246
Residential Psychiatric Treatment Centers	$23,611,943
Transportation	$21,206,322
Older Alaskans Waiver	$14,723,800

*Mental Retardation and Developmental Disabilities

Fastest Growing Categories of Service (3-Year Average)	
Adults with Physical Disabilities Waiver	81%
Residential Psychiatric Treatment Centers	78%
CCMC Waiver**	51%
MRDD Waiver*	41%
Older Alaskans Waiver	31%
Transportation	23%
Pharmacy	21%
Physician Services	20%
Psychiatric Hospitals	18%
Nursing Homes	4%

** Children with Complex Medical Conditions

Proposed Medicaid re-financing options

Refinancing options will reduce the Medicaid general fund request to $7.9 million, except for the fund source change of $18.7 million GF increase due to federal changes to Alaska's Pro-Share program. The division is proposing the Alaska Medicaid Fair-Share Program. This arrangement will make an additional payment for services to Medicaid-eligible beneficiaries to hospitals operated by Alaskan Tribes, up to the payment limit applicable. The hospitals will return 90 percent of the payment to the Medicaid program as statutory designated program receipts that can be used as match for Medicaid service payments. The result is a net savings of $44.3 million in general fund requirements for Medicaid.

In addition, private hospital re-financing options are being considered. The division will make additional payments of $31.7 million to private hospitals up to the aggregate Medicare Upper Payment Limit. The hospitals will retain 5 percent of the payment to pay for state-funded programs previously paid for with direct state grants or contracts. It is anticipated that up to 95 percent of the funds made available, $11.8 million, will be appropriated to the Medicaid Services BRU to cover state match requirements.

Federal funding policy changes

The Federal Medical Assistance Percentage (FMAP) rate was decreased to 57.38 percent for federal fiscal year 2002. Early federal estimates indicate federal fiscal year 2003 will increase slightly to 58.22 percent. These changes are significant and carry with them a projected loss of $10.8 million in federal fund participation if Congressional changes don't continue.

Medicaid Program Incremental Request: $26.6 million general funds, $50.1 other funds, $200.6 federal funds: Total $277.3 million.

Mental Health Funding

'The evidence is strong that over 90 percent of children and adolescents who commit suicide have a mental disorder…'

…Surgeon General's Report on Mental Health, 1999

~

'More often, culture bears upon whether people even seek help in the first place, what types of help they seek, what coping styles and social supports they have, and how much stigma they attach to mental illness.'

…Surgeon General's Report on Mental Health, 1999

~

'In reality alcohol is the most widely used and abused drug in America. One in four children under 18 years old in the United States lives with a chemically dependent parent.'

…National Clearinghouse for Alcohol and Drug Information, 2001

~

'Staff turnover is a significant problem throughout Alaska due to poor pay, isolation, and burnout.'

In Step-The Plan, Comprehensive Integrated Mental Health Plan, 2001

What's The Program?

The beneficiaries of the Mental Health Trust are Alaskans who experience mental illness; mental retardation or similar disabilities; chronic alcoholism with psychosis; or Alzheimer's disease or related dementia. Funding for DHSS programs that support those beneficiaries includes Mental Health Trust Authority Authorized Receipts (MHTAAR) and General Fund/Mental Health (GF/MH) funding.

What Should Be Done?

- **Safety, Quality Assurance**

At both the state and provider levels, difficulty in recruiting and retaining quality staff is of increasing concern. Relative to Alaska's cost of living, local wages are no longer keeping pace with those in much of the lower 48. Service providers' struggle to both attract and retain qualified staff affects not only the quality of services provided, but also the basic safety and community participation of individuals receiving these services. Without adequate, qualified provider staff, many consumers will be at risk of placement in institutions, which are a far greater cost to the state than current efforts to support the existing community infrastructure.

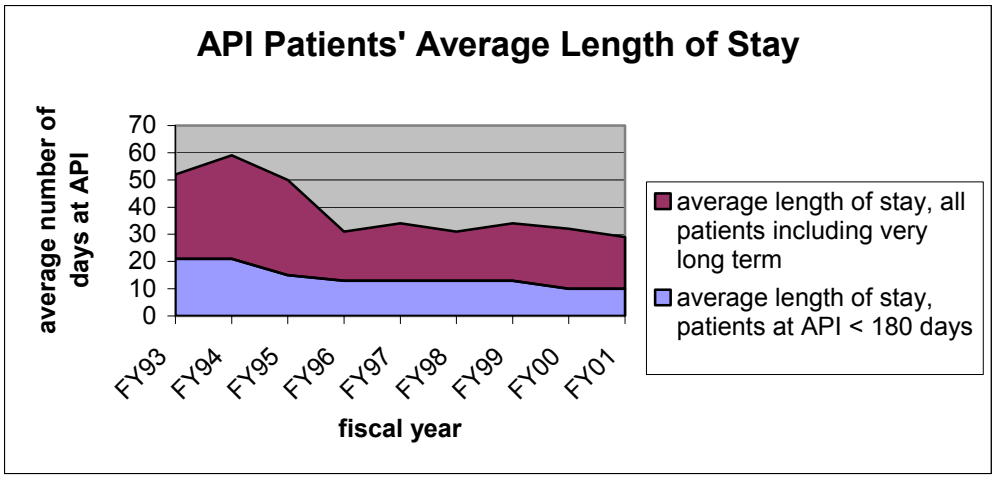
Some examples requested in the FY2003 budget are:

The Assisted Living Home Rate Increase, part of a three-year plan approved by the Legislature (fund change -$459.0 MHTAAR, $952.8 GF/MH), raises the daily rate from $60 to $70 for fiscal 2003,

Developmental Disabilities Infrastructure, provides funds (fund change, -$120.0 MHTAAR, $120.0 GF/MH) to Developmental Disabilities grantees to increase salary levels and benefits to both retain and attract qualified staff; ensure that employees receive adequate training to provide quality services,

Safety and Quality Assurance, provides funding ($360.5 GF/MH) for the division to consolidate and expand its efforts related to safety and quality care by implementing a new Safety & Quality Assurance unit,

Covering Loss of Disproportionate Share Hospital (DSH) Revenue, provides funding (-$491.5 MHTAAR, -$877.5 I/A Receipts DSH loss, $1,249.2 GF/MH, $700.0 I/A Receipts) to offset the loss of DSH funds to the Alaska Psychiatric Institute (API). These funds will be used to provide staffing for patient care, to purchase pharmaceuticals, and to help cover the cost of medical and dental contracts.



- **Make More Services Available Locally**

In 1999, the U.S. Supreme Court ruled that people with mental illnesses are entitled to treatment and services in their communities. The federal government subsequently has cut funding for mental institutions. One of the challenges is to fill the gap with an array of new community-based services for all of the people covered by the beneficiary definition. The geographic size and widespread population in Alaska accentuate this need.

Some examples of requests in the FY2003 budget are:

Regional Community DD Grantee Support/Training, provides funding ($250.0 I/A Receipts) for systemic change and staff training effort to meet dynamic challenges in areas such as eligibility determination.

Community Mental Health/API Replacement – Enhanced Crisis Respite, ($495.6 GF/MH) is a transitional program that offers a less restrictive service for adult consumers who may be experiencing an acute psychiatric crisis as they leave the Alaska Psychiatric Institute.

- **Provide Programs To Serve All Ages, Cultures And Genders**

The needs of these consumers vary across such factors as age, gender, race and culture. All of these factors need to be acknowledged in identifying the specific needs of each consumer.

Some examples of requests in the FY2003 budget are:

Mini-Grants for Beneficiaries with Developmental Disabilities, provides ($25.0 MHTAAR) beneficiaries with a broad range of equipment and services that are essential to directly improving their quality of life and increasing independent functioning,

Alaska Birth Defects Registry, provides funding (fund change, -$150.0 Fed Receipts, $150.0 GF/MH) to identify children expected to have special health care needs and to provide vital information about the frequency and distribution of birth defects.

Smart Start / Strong Future

Health, Safety and Success for Alaska's Children – funded with $9.2m general funds and $4.1m tobacco settlement; federal dollars pending

The well-being of Alaska's children has been a top priority of the Knowles/Ulmer Administration and its Children's Cabinet. Research backs up what the Children's Cabinet has recommended – if we take care of children early on, they will take better care of themselves later on. The current initiative continues the progress begun under *SMART START* and has three goals: improve child health; keep children safe; and help children succeed.

Healthy Children — $3.7 million of general funds plus $5.4 tobacco and other funds

Reduce tobacco use, especially among young people. More than one out of four Alaskans is addicted to tobacco, a substance that kills half of all long-term users. An additional $4.1 million of the 20% set aside from the tobacco settlement will build prevention and cessation programs that save lives by preventing youth smoking. With this additional investment, Alaska will spend $7.4 million from the settlement on anti-tobacco programs in FY2003.

Expand alcohol treatment for women and children. $1.2 million will build treatment capacity so the 61 women on the wait list can enter treatment with their children, resulting in fewer children placed in foster homes. Another $839,100 will expand the juvenile alcohol safety program beyond the current four pilot sites and provide funds for youth treatment.

Prevent inhalant abuse among young people. One in five students have used an inhalant to get high by the time he/she reaches the eighth grade. $470,000 will be used in nine to twelve communities each year to reduce inhalant abuse among children and youth.

Improve children's overall health. Since children learn best in a healthy environment, the Department of Environmental Conservation will incorporate environmental health training and outreach into existing programs for school and day care facilities. The project will focus on drinking water, wastewater, sanitation, food safety, pesticide management and indoor air quality. New mental health clinicians in the Division of Family and Youth Services will help social workers and foster parents work with special needs children. The Infant Learning Program will be able to increase services for difficult to serve children. The WIC-Farmers Market will be expanded to improve the health and nutrition of women, infants and children while supporting Alaska's farmers.

Prevent suicides. Alaska leads the nation in suicides. Alaska's rate of 23.7 per 100,000 is over twice the national average. The Alaska Native teen suicide rate is an even more alarming 197.5 per 100,000. A $500,000 expansion of suicide prevention grants will provide up to 35 counselors who can intervene or provide community training, intervention and referrals.

Safe Children —$4.9 million general funds plus $2.7 million federal and other funds

Zero tolerance for child abuse and neglect. The goal of zero tolerance is to respond to all legitimate child abuse reports of harm. With $825,000, State Troopers will be able to respond to all high priority child abuse and sexual abuse reports within 24 hours. $975,000 will expand the Family Assessment Response grant program beyond the pilot site in Mat-Su to the three areas where social workers cannot respond to 100% of the calls (Fairbanks, Bethel and Kenai).

Alaska has one of the highest rates of child abuse and neglect in the US. $1 million in federal funds will expand Child Advocacy Center programs, which provide a central, less traumatic setting for child abuse investigations. Mental Health stabilization homes will provide short-term beds for children

waiting for a permanent home. In Corrections, $500,000 will provide probation officers for specialized caseloads for dual-diagnosis offenders with children. Research demonstrates that increased supervision coupled with participation in accountability programs can significantly reduce the number of violations by offenders.

Protect and support children in state custody. There are approximately 1,900 children in out-of home care. Children in state custody can be difficult and often have many challenges. Most children in foster care eventually return home; visits between children and parents can reduce the time a child stays in state custody. $750,000 will implement Family Visitation Centers in Anchorage, Fairbanks, Mat-Su, Kenai, Juneau and Bethel, so parents can visit children in a neutral setting.

The Health Passport Project is a $579,000 joint effort between the Division of Family and Youth Services and Public Health Nursing to provide every child in foster care with a documented health history. Relatives can often provide the best foster placement for a child in state custody, but social workers sometimes have difficulty finding them. $60,000 will start a pilot project in Anchorage to help caseworkers locate adult relatives of children in state custody.

Improve results for those who commit crimes and their families. Alaska's average juvenile probation officer caseload is 31 to 1. The National Advisory Council recommends an intensive caseload of 12 to 1. Seven new juvenile probation officers can be added for $500,000 to reduce the caseload to 28 to 1, which is still well above recommended levels. To help children whose parents are in prison, $515,000 will add case managers to identify at-risk children and collaborate with community programs to provide early intervention and ongoing support during the parents' sentence.

Help foster parents. Foster parents are paid an average of $22.34 per day, a rate set in 1998 with the initial *SMART START* initiative. Alaska needs foster parents, but in a March 2001 survey by the University of Alaska Anchorage, 40% said the monetary stipend was inadequate to meet the basic needs of a foster child. The current rate was based on 1993 federal poverty guidelines and does not reflect the 23.45% increase in the cost of living increase since then. $1.3 million will increase the Foster Care Base Rate by $3.02 to $25.36 per day.

Successful Children — $600,000 of general funds, plus federal funds

Promote early childhood literacy. Improving the early language development of children 0-8 years is the cornerstone for successful reading. With a $100,000 investment, an early literacy project will coordinate existing resources and new federal funds to ensure the effective delivery of age appropriate early literacy instruction by parents, care givers, educators and student assistants.

Improve child care quality. Training is a key component of improving the quality of early care and education. The Alaska Vocational Technical Center has an early childhood education professional development project to train child care workers up through the Certified Development Associate level. Funding for the instructor will come from the joint state-university System for Early Education Development (SEED) project.

$500,000 in state general funds will be used to strengthen existing Head Start programs, expand service to additional children and families, assist programs in meeting federal Head Start performance requirements, and help grantees meet the 20% matching requirement to access new federal program funds.

Improve K-12 education. In addition to *SMART START / STRONG FUTURE*, the Governor supports the full Year 2 recommendation of the Education Funding Task Force for additional resources to improve student and school performance. $31 million is proposed in legislation; $1.7 million is in the operating budget for the Department of Education and Early Development.

all dollars in thousands

	Dept	General Funds	Federal Funds	Other Funds
Healthy Children				
Reduce Tobacco Use, Especially Among Children				
Tobacco program increase from $3 million to $7.12 million (Legislation will establish Tobacco Control Board: $296.1)	HSS			$4,123.9
Expand Alcohol Treatment				
Alcohol Treatment for Women with Children	HSS	$1,241.0 (plus 750.0 capital)		
Juvenile Alcohol Intervention (ASAP) and Treatment	HSS	$839.1		
Fight Inhalant Abuse				
Alaskans Collaborating for Teens	HSS	$470.0		
Improve Children's Health				
Child Health Indicators Program	HSS, Educ	$90.0		
Federal Farmers Market - WIC Program Increase	HSS	$78.4	$1,200.0	
Mental Health clinicians to help foster parents with special needs children	HSS	$86.0		$86.0
Infant Learning Program service expansion	HSS	$200.0		
Children's Environmental Health Project	DEC	$175.0		
Suicide Prevention Council and grant funds	HSS	$500.0		
Healthy Children		**$3,679.5**	**$1,200.0**	**$4,209.9**
Safe Children				
Zero Tolerance - Respond to all Reports of Harm				
Child Protection Investigators	Pub Saf	$825.0		
Family Assessment Response Program Expansion	HSS	$975.0		
Child Advocacy Centers	HSS		$1,000.0	
Mental Health Stabilization Home	HSS	$50.0		$600.0
Family Visitation Centers	HSS	$750.0		
Family Futures - Probation/Parole Officers for Offenders with Children	Corr	$471.2		$28.8
Protect and Support Children in State Custody				
Health Passport Project	HSS	$145.1		$434.7
Relative Navigators Pilot Project	HSS	$50.0	$10.0	
Foster Care Base Rate increase	HSS	$909.5	$349.0	
Improve Results for Those Who Commit Crimes				
Juvenile Probation Officers	HSS	$500.0		
Help Children with Parents in Prison	HSS, Corr	$250.0		$265.0
Safe Children		**$4,925.8**	**$1,359.0**	**$1,328.5**
Successful Children				
Promote Early Childhood Literacy	Educ	$100.0		
Improve Child Care Quality				
AVTEC Child Development Instructor	Educ			$65.0
Head Start Funding	Educ	$500.0	federal amount not yet known	
Successful Children		**$600.0**	**$0.0**	**$65.0**
Total for Smart Start / Strong Future		**$9,205.3**	**$2,559.0**	**$5,603.4**
			All Funds Total:	**$17,367.7**

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Division of Public Assistance

Mission

The mission of the Division of Public Assistance is to provide basic living expenses and self-sufficiency services to Alaskans in need.

Introduction

To meet this mission, the Division administers programs that provide temporary economic support to needy families and individuals, financial assistance to the elderly, blind and disabled, benefits to supplement nutrition, medical benefits, and supportive services that enable and encourage welfare recipients to pursue economic independence and self-sufficiency.

The Division provides services to help children and families remain safe and healthy by:

- Providing assistance to needy families so they can care for their children in their own homes, providing the basic needs of shelter, home heating, clothing, transportation and food.
- Encouraging family self-sufficiency and stability through employment, receipt of child support and prevention of unplanned and out-of-wedlock pregnancies.
- Providing financial assistance to needy aged, blind, or disabled Alaskans to help them meet their basic needs, stay in their own homes and avoid costly institutional placements.
- Reducing the disproportionate burden of home heating costs on the poor.
- Providing access to food support and decrease the incidence of food insecurity among Alaskans.
- Determining eligibility for Medicaid and child health insurance.

Unemployment, illness, and other personal emergencies can threaten the well being of any Alaskan and create the need to seek public assistance. One out of every eight Alaskans requests some type of cash, food, medical, or energy assistance from the Division. In the last fiscal year, the division assisted approximately 43,000 families each month. While many families and individuals are served only seasonally or for a short period of need, an estimated 90,000 persons will receive some form of assistance in the coming year.

Annual Statistical Summary of Services in FY2001

Comparison of Public Assistance Programs

	ATAP/TANF		Adult Public Assistance		General Relief		Food Stamps	
FY01 Cases avg. mo.	7,421		13,911		144		13,775	
# of clients avg. mo.	22,114		13,911		215		41,330	
Race Distribution	White	46%	White	50%	White	65%	White	45%
	Alaska Native	37%	Alaska Native	30%	Alaska Native	16%	Alaska Native	39%
	Black	8%	Asian	8%	Black	9%	Black	6%
	Hispanic	3%	Black	5%			Hispanic	3%
Recipients by Location (District area)	Anch / Mat-Su	50%	Anch / Mat-Su	51%	Anch / Mat-Su	64%	Anch / Mat-Su	43%
	Northern	12%	Northern	14%	Northern	16%	Northern	14%
	Southeast	11%	Southeast	11%	Southeast	12%	Southeast	12%
	Balance of State	27%	Balance of State	24%	Balance of State	8%	Balance of State	31%
Expenditure By Category of Service	Single parent	70%	Disabled	66%	Burial service	75%	FS and ATAP	33%
	Two parent	14%	Aged	33%	Rent assistance	22%	FS only	31%
	Child only	16%	Blind	1%	Other	3%	FS and APA	20%
							FS and Med	16%
Persons by age group								
Children 0 - 18 yrs	14,879		0		20		22,631	
Adults 19 - 59 yrs	7,235		8,041		178		17,014	
Adults 60 - older			5,870		17		1,685	
Total Expenditures	$59,522,300		$51,818,700		$945,600		$46,092,800	
Federal	$ 14,744,000		$897,900				$46,092,800	
GF	$ 39,927,300		$ 47,483,500		$945,600			
Other	$ 4,851,000		$3,437,300					

Note: Percentages do not necessarily add to 100%. Only major representative groups, locations or categories of service are listed.

COMPARISON OF PUBLIC ASSISTANCE PROGRAMS

	OAA-ALBHH		Heating Assistance		Child Care (PASS I only)	
FY01 Cases avg. monthy	1,308		7,966 per year			
# of clients avg. monthly	1,308		23,898 per year		2,304 children	
Race Distribution	N/A		White	57%	N/A	
			Alaska Native	35%		
			Black	3%		
			Asian	4%		
Recipients by Location (District area)	N/A				N/A	
			Anch / Mat-Su	48%		
			Northern	16%		
			Southeast	6%		
			Balance of State	30%		
Expenditure By Category of Service	Aged	100%	Employed, or temp unemployed	57%	PASS I	100%
			Receiving ATAP	18%		
			Receiving APA	24%		
Total Expenditures	$1,962,300		$9,030,011		$9,403,700	
Federal			$9,030,011		$6,403,700	
GF	$1,962,300				$3,000,000	
Other						

Note: Percentages do not necessarily add to 100%. Only major representative groups, locations or categories of services are listed.
1) ATAP/TANF caseload and expenditure includes the Alaska Temporary Assistance Program and the Native Family Assistance Program.
2) The DHSS Child Care Benefits component provides PASS I (child care subsidy authorized by DPA for families also receiving ATAP) an funding to the Department of Education and Early Development to support their child care programs. The number of children served and child care subsidy administered by EED are not included above.
3) Several areas of Alaska receive Energy Assistance through tribal organizations funded directly by the federal government.
In FY00 Heating Assistance Program expenditures include special emergency LIHEAP funds for the high cost of fuel.

List of Primary Programs and Statutory Responsibilities

Alaska Temporary Assistance Program AS 47.27.005
The Alaska Temporary Assistance Program (ATAP) was created by the state and federal welfare reform laws passed in 1996. The Temporary Assistance program provides temporary financial assistance to eligible needy families when the parents or caretaker relatives are temporarily unemployed, currently under-employed, or experience barriers to gainful employment. Work requirements encourage more families to gain employment and move off assistance. There is a 60 month lifetime limit on benefits.

Child Care Services AS 47.27.635
Providing access to child care is a key component in the state's efforts to move more parents into full-time jobs and more families toward self-sufficiency. The federal Temporary Assistance for Needy Families (TANF) block grant and the required state general fund maintenance of effort provide child care subsidies for families in welfare-to-work activities; families moving off of welfare due employment and working families whose low income places them at risk of needing assistance. The Departments of Health & Social Services and Education & Early Development are working together to make quality child care more available and more affordable. This, in turn, has helped families avoid reliance on public assistance. The state's continued commitment to improving the quality, availability, and affordability of child care will help ensure that even more families are able to become and remain self-sufficient.

Work Services AS 47.27.005
With the Temporary Assistance program focus on moving welfare recipients into the workforce, there is greater need to help individuals with low skills, a lack of work history and other challenges to work. The array of services intended to help recipients into the workforce is referred to as Work Services. Changes in welfare benefit determinations make it always pay more for a recipient to work rather than to be on Temporary Assistance. Recognizing that many welfare recipients must overcome substantial challenges in order to find and retain employment, Alaska's Work Services include assistance in job readiness and job search, case management, job retention and advancement, basic education, training, and transportation to work. Community-based grantees and contractors deliver a majority of the Work Services. In FY02, over 25 different grants or contracts were issued to Native organizations and other non-profit organizations to assist recipients in their communities move from welfare to work.

Native TANF Program AS 47.27.070
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the federal welfare reform law) authorizes certain Alaska Regional native non-profit organizations, to administer Temporary Assistance for Needy Families (TANF) programs and to receive federal direct funding. In FY2000 the Legislature passed a bill authorizing four Native Organizations in Alaska to run Native TANF programs. The Tanana Chiefs Conference (TCC), Association of Village Council Presidents, Inc. (AVCP) and Central Council of Tlingit & Haida Indian Tribes (T&H) have taken advantage of this opportunity to design their own culturally relevant and regionally focused welfare programs. Funding for Native Family Assistance program operation comes from the federal TANF block grant and is supplemented by state funds that would otherwise be spent to serve the same Native welfare recipients. Funds provided by the state grant are used for the purpose of providing

temporary assistance benefits to eligible families through the organization now administering the Native Family Assistance program.

Adult Public Assistance AS 47.25.430
Adult Public Assistance (APA) is a state funded program that provides cash assistance to needy aged, blind, and disabled persons who meet certain income and resource requirements. People who receive APA financial assistance are over 65 years old or have severe and long-term disabilities that impose mental and physical limitations on their day-to-day functioning. Continued APA funding provides critical financial assistance to enable program participants to live as independently as possible.

Food Stamp Program AS 47.25.975
The Food Stamp Program helps low-income households maintain adequate nutrition. Food Stamp benefits are used to purchase food products from more than 500 retail grocery stores throughout Alaska. Benefits vary with household size, income and place of residence. Participants in rural communities get larger monthly benefits to compensate for higher food costs. Average monthly benefits range from about $200 in larger communities to around $550 in our southwest and northwest Alaska towns and villages. Benefits are 100 percent federally funded by the U.S. Department of Agriculture. The state and federal government share the administrative cost of the program equally.

Heating Assistance Program
The Heating Assistance Program (HAP) is 100 percent federally funded by the Low Income Home Energy Assistance Program (LIHEAP) Block Grant. The program provides seasonal help with home heating costs to low-income households. In FY00, around $4.3 million was provided to approximately 7,300 households. Benefits are based on family income, home heating costs, housing type and geographic region. Heating assistance payments—primarily made to home heating suppliers on behalf of eligible households—cover the cost of heating oil, natural gas, electricity, propane, wood, and coal. The grants are given once per program year per household.

General Relief Assistance AS 47.25.120
Alaska's General Relief Assistance (GRA) program provides for the most basic needs of many Alaskans who haven't the personal resources to meet an emergent need and who are not eligible for other assistance programs offered by the state. GRA is designed to meet the immediate, basic needs of Alaskans facing extreme financial crisis. Examples of basic needs are shelter and utilities. Under limited circumstances, GRA can provide assistance for clothing and food for persons not eligible to receive food stamps. Approximately seventy percent of the GRA appropriation funds indigent burials.

Medicaid Eligibility AS 47.07.010
Medicaid, an entitlement program created by the federal government, is the primary public program financing basic health and long-term care services for low-income Alaskans. The Division of Medical Assistance is responsible for program and policy development and provider payments. The Division of Public Assistance is responsible for determining the eligibility of individuals and families in need of Medicaid benefits, including children and pregnant woman under the Denali KidCare Program. The majority of Medicaid recipients are beneficiaries of other programs and services administered and delivered by DPA. Most recipients on the Alaska Temporary Assistance

Program receive family Medicaid benefits. Many children, young adults, and elderly or disabled persons receiving Medicaid also receive food stamps or adult public assistance benefits.

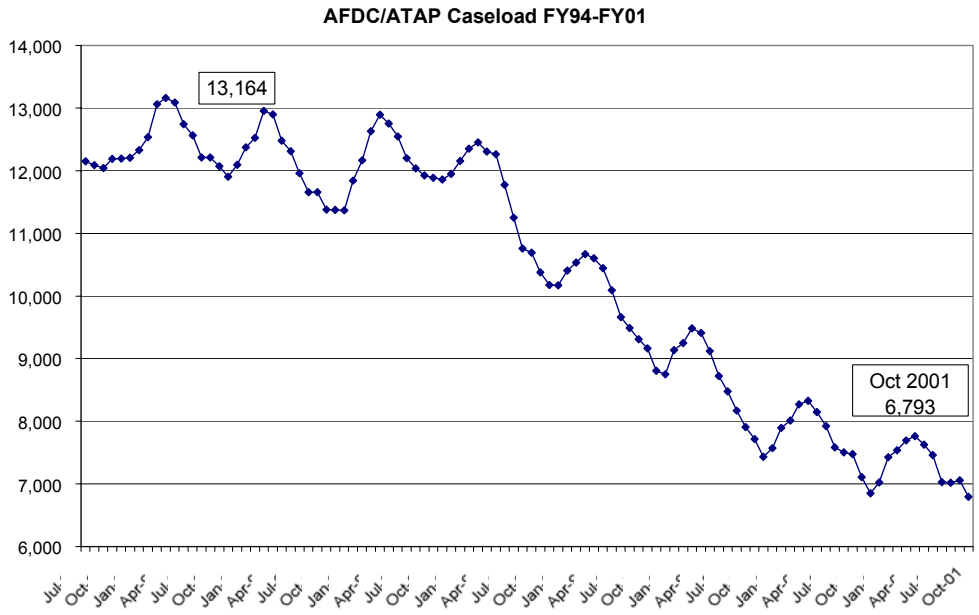
ATAP

The focus of welfare reform and the Alaska Temporary Assistance Program (ATAP) is to provide temporary economic assistance to poor families and to assist families off assistance, out of poverty and toward self-sufficiency through employment as quickly as possible.

Due to declining caseloads and the reduced demand for cash benefit payments, millions of dollars have been made available to provide child care and work services for recipients and working families and to save state funds for other services, which has helped to reduce the state's budget deficit.

ATAP Caseload Continues to Decline

In October 2001, the Alaska TANF caseload declined to 6,793. This figure is 48% below the historical peak of 13,164 in April of 1994. The ATAP caseload has dropped 43% from October 1996 to October 2001. The steady decline began in February 1997 when the first ATAP provisions took effect and has continued, interrupted only by the regular seasonal upswing during the winter months.

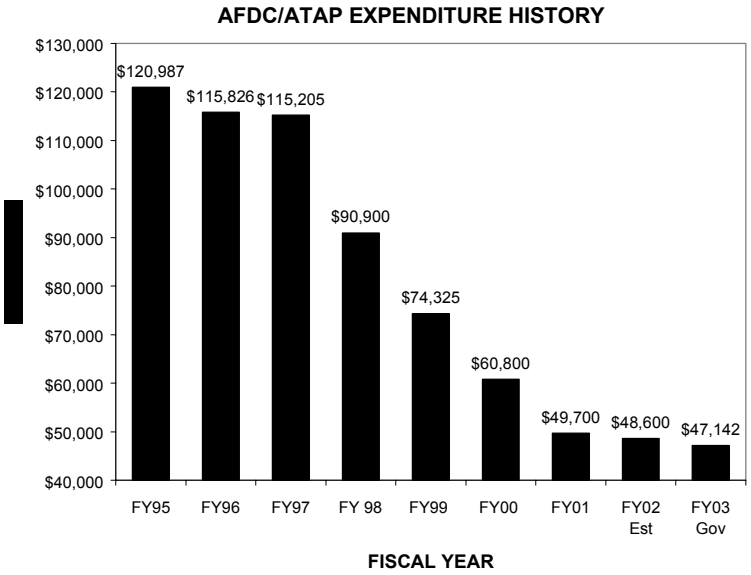


ATAP Benefit Expenditures Down

Spending on welfare payments is down. In FY01, these expenditures declined to $50 million, a 57% reduction from FY97. The Governor's request for FY2003 anticipates a further decline to $47 million. Declining expenditures since welfare reform was implemented in 1997, can be attributed to more recipients leaving welfare for work, more recipients working, benefit cuts to two-parent families, and reductions due to lower housing costs.

It is very important to note that the earliest caseload reductions are the easiest. Caseload reductions are slowing down since recipients remaining on the caseload are those with more serious challenges to employment. Many states are experiencing rising caseloads due to the current economic recession. It is hard to predict how the changing economy will affect Alaska's ATAP caseload.

The 5-year limit on Temporary Assistance is a key element of welfare reform. July 2002, marks the first month a number of families in Alaska will face the 60-month time limit for receiving Temporary Assistance and some families will run out of time. DPA's goal remains to move Alaskans from welfare to jobs so they can support their families while maintaining a safety net for those truly in need.



Sustaining and building on the successes of Alaska's welfare reform efforts is a pivotal issue that requires:

- Investing in working families by expanding and enhancing services to improve job retention and advancement
- Moving families with serious challenges to self-sufficiency off welfare prior to reaching time limits
- Supporting the development and implementation of Native family assistance programs
- Serving families living in communities with limited employment opportunities
- Sustaining caseload reductions and program savings while protecting the well-being of children in needy families

FY2003 ATAP component budget

The FY2003 Governor's request reduces the ATAP formula budget by $2,974.4 compared to FY2002 authorized. The ATAP benefit savings from continued caseload reductions are needed to sustain budgets for work services, child care and other services at the FY2002 approved level.

Federal TANF Reauthorization and Supplemental grants for High Population Growth

Federal funding for the TANF block grant expires in FY2003. At the same time Alaska is preparing for the imposition of the 60-month limit, Congress will be debating reauthorization of the federal welfare reform law. The entire law may be reconsidered including the purpose, block grant funding level, work requirements and time limits. States will undoubtedly want to retain their current federal funding and the flexibility that allowed them to be so successful.

Alaska was one of seventeen states who qualified for supplemental TANF grants for fiscal years 1998 through 2001 (based on population increases in 1990-1994). This supplemental grant program expired one year before the expiration of the overall TANF program and if nothing is done

to extend it, the 17 eligible states face a reduction in their TANF funding of 10-13% in current FY2002. Congress has not yet approved funding that would extend TANF supplemental grants for at least one year for FY2002. States hope that the supplemental grants will also be reconsidered this year during reauthorization of the entire TANF program in FY2003.

Even if Congress reauthorizes TANF block grant funding at its current baseline level, we may not have enough federal TANF money to sustain even our current FY2002 spending plans. We have relied on TANF surplus balances and the TANF supplemental grants from prior years to increase and sustain TANF financing for ATAP and non-ATAP services. However, the surplus balances will likely be fully spent by the end of FFY2002, leaving us with only the annual FY2003 baseline TANF grant to finance the year's TANF spending.

Sustaining Reinvestments Critical to Welfare Reform

Welfare reform has saved millions of state general fund dollars at a critical time of high budget deficits. Due to declining caseloads and the reduced demand for cash benefit payments, millions of dollars have been made available to provide child care and work services for recipients and to replace state funds for other services. Some of the savings have been reinvested in services for ATAP recipients, but most of the savings have been used to reduce state general fund (GF) obligations.

The portion of the savings that has been used to reduce the state's GF obligation is summarized below. Comparing what was spent in FY97 to the amount for FY02, the total general fund savings reached $47.9 million in FY02. This sum is composed of several factors: 1) $20.2 million by reducing the required state effort to the MOE floor by deleting GF from the ATAP payments component; 2) $17.7 million using federal TANF dollars to replace GF funded Child Care, Head Start, Victims of Domestic Violence, Child Protection and Healthy Families Home Visitation services; and 3) $10.0 million using federal TANF dollars to provide additional Child Protection services and Child Care that would otherwise be funded with GF.

State Maintenance of Effort (MOE) under TANF

Under the TANF federal block grant, states are required to maintain state spending for TANF at a level no less than 80% of our state spending under AFDC in federal fiscal year 1994. This is referred to as the maintenance of effort (MOE). To qualify as state MOE for TANF, the state GF expenditure must be made to or on behalf of a family eligible for ATAP. The majority of MOE expenditures finance ATAP cash payments, ATAP eligibility determination and benefit authorization activity, work services that help ATAP families into the workforce, and child care for ATAP families working their way off welfare. States failing to meet the MOE level are penalized by a dollar-for-dollar reduction in their annual federal TANF block grant allotment and are required to replace lost federal dollars with state funds. No state has violated the required MOE.

For Alaska, this MOE establishes a floor of approximately $44 million that must be met to comply with federally mandated MOE. State general funds savings from falling ATAP caseloads have been previously deleted from the ATAP budget to a level equal to the minimum MOE amount. The FY2003 total state GF for all ATAP (TANF) services remains at the MOE floor. Any additional GF reduction would place Alaska below its TANF MOE requirement.

Federal TANF expenditures and Account Balances

The TANF block grant amount is available to states for five years. States may reserve unspent and unobligated surplus federal funds and roll them over in the federal account from one fiscal year to

another. Use of any unspent balance is somewhat restrictive, meaning that carryover funds can be used primarily for cash assistance. The declining ATAP caseloads have made available additional surplus balances that exceed the amount needed to meet required commitments under the ATAP program. The state GF share of these savings have been deleted from ATAP to the MOE floor and the surplus federal TANF shares transferred to other block grants producing additional state general fund savings. Under the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (P.L. 104-193), states may transfer up to 30 percent of their total TANF block grant to other federal grants. Up to 30 percent of the TANF funds can be directed to the Child Care Development Fund (CCDF) and no more the 10% of the total funds transferred may be directed to the Social Services Block Grant (SSBG), Title XX. Further, the funds transferred into SSBG must be used to serve children and families with income below 200 percent of poverty.

The FY2003 Governor's budget assumes transfers totaling $18.4 million TANF funds to the CCDF, to help finance low income child care and related services administered by the Department of Education and Early Development (EED). The FY2003 budget will use $3.1 million TANF transfers to the SSBG for child protection services. The FY2003 budget also continues federal TANF funding of $2.6 million for family services supplementing EED's Head Start component activity, $1.0 million for Healthy Families Home Visitation services, and $1.3 million supporting victims of domestic violence.

DPA is able to achieve the current federal TANF balance by continued ATAP caseload reductions, much of which is due to the emphasis on self-sufficiency and buoyed by the moderately strong economy. If the economy slows, it is prudent to expect some increase, or at least leveling, in the caseload. This potential could impact the level of formula ATAP payments and the federal TANF grant balance available to sustain transfers to other block grants for non-ATAP services.

FY2003 Work Services budget maintains funding at current FY2002 level

The FY2003 Work Services budget sustains FY2002 level investments in welfare-to-work contract services and client supportive services to help move poor Alaskans into jobs so they can support their families. Investments that put people to work reduce welfare dependency and the cost of ATAP. With welfare reform's concerted focus on moving welfare recipients into the workforce, it is evident there is greater need to help individuals with low skills, a lack of work history and other barriers from welfare to work. The services intended to help recipients into the workforce are referred to as Work Services.

FY2003 Child Care Benefits budget maintains funding at current FY2002 level

The success of welfare reform depends on the existence of accessible, affordable, quality child care for all low wage workers. Parents on Temporary Assistance do not have the income to pay for child care to allow them to go to work. If a parent has more than two children, their child care costs can often be more than their monthly income. As parents on Temporary Assistance enter the workforce, child care subsidies must be provided to enable parents to stay employed and to move off Temporary Assistance.

Child care assistance for families transitioning from public assistance can often make the difference between unemployment and a return to public assistance, and employment leading to self-sufficiency. As the welfare caseloads have dropped, the demand for child care has risen dramatically. Alaska has always been able to fully fund child care for ATAP families while they are on ATAP and for one year after they leave. Shortfalls in child care assistance funding prevents low-income families from obtaining and maintaining employment and place them at risk of

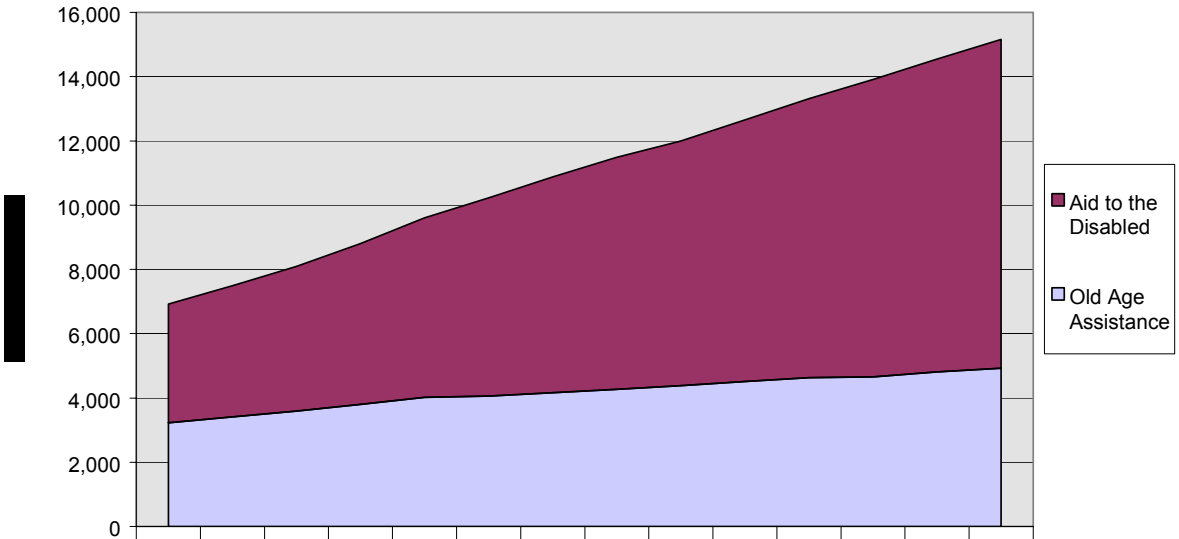
requiring public assistance. Sufficient funding for all of the subsidy programs is necessary to allow parents to enter and stay in the work force.

In summary, the FY2003 DHSS/DPA Child Care Benefits component total is $33,102.0 that finances the following services: $12,170.3 for child care for ATAP families where the subsidy is authorized and paid by DPA; $18,357.5 contractual for an RSA to EED financing child care subsidy and related services; and $2,574.2 contractual for an RSA to EED for services to families on ATAP through EED's Head Start program component.

FY2002 Adult Public Assistance (APA) component

The Adult Public Assistance Program (APA) provides financial assistance and access to medical care for 4,924 elderly and 10,232 disabled Alaskans. The program was created to supplement Social Security disability benefits and provides the recipient with the income support needed to remain as independent as possible in the community. To be eligible for APA, a low-income individual must be over 64 or at least 18 years of age, blind, or diagnosed by a physician as permanently disabled, chronically ill, or terminally ill. Applicants must also undergo a rigorous process to determine that their mental or physical limitations make them temporarily or permanently incapable of self-support through gainful employment. Each month benefits are issued to APA clients in an amount equal to the maximum supplemental payment scheduled less adjustment for any income the individual receives. APA benefits help many Alaskans avert problems such as homelessness and avoid higher cost settings such as hospitals, nursing homes or incarceration.

Adult Public Assistance Caseload Projection



	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002 Est	2003 Gov
Total APA	6,918	7,500	8,089	8,807	9,605	10,236	10,884	11,487	11,990	12,655	13,312	13,911	14,551	15,156
Aid to the Disabled	3,690	4,086	4,491	5,005	5,581	6,172	6,722	7,227	7,605	8,147	8,687	9,250	9,747	10,232
Old Age Assistance	3,228	3,414	3,598	3,802	4,024	4,064	4,162	4,260	4,385	4,508	4,625	4,661	4,804	4,924

Formula Need for Adult Public Assistance requires FY2003 increment of $2,531.6 GF & $90.0 I/A

The number of elderly and disabled Alaskans who rely on the APA program to meet basic needs has steadily increased – a trend that is expected to continue. The APA population is expected to continue to grow at 4.2% from 14,551 in FY2002 to 15,156 in FY2003. The APA program was short-funded by the Legislature in FY2002. The initial budget funds an APA population increase of 3% but we expect a caseload increase of about 4.6%. The total FY2003 formula increment is comprised of the FY2002 supplemental need and the projected formula increase for FY2003 caseload growth. The reasons for this growth appear to be a combination of increased state population, improved medical technology and an aging "baby boom" cohort. Growth in this program is sustained in part by the long-term needs of recipients - to qualify for APA benefits, an individual must be elderly or have a permanent disability, and therefore this population tends to need to rely on the APA program for the remainder of their entire adult lives. Continued APA funding provides critical assistance as the program of last resort for this population.

Helping Disabled Who Can Work

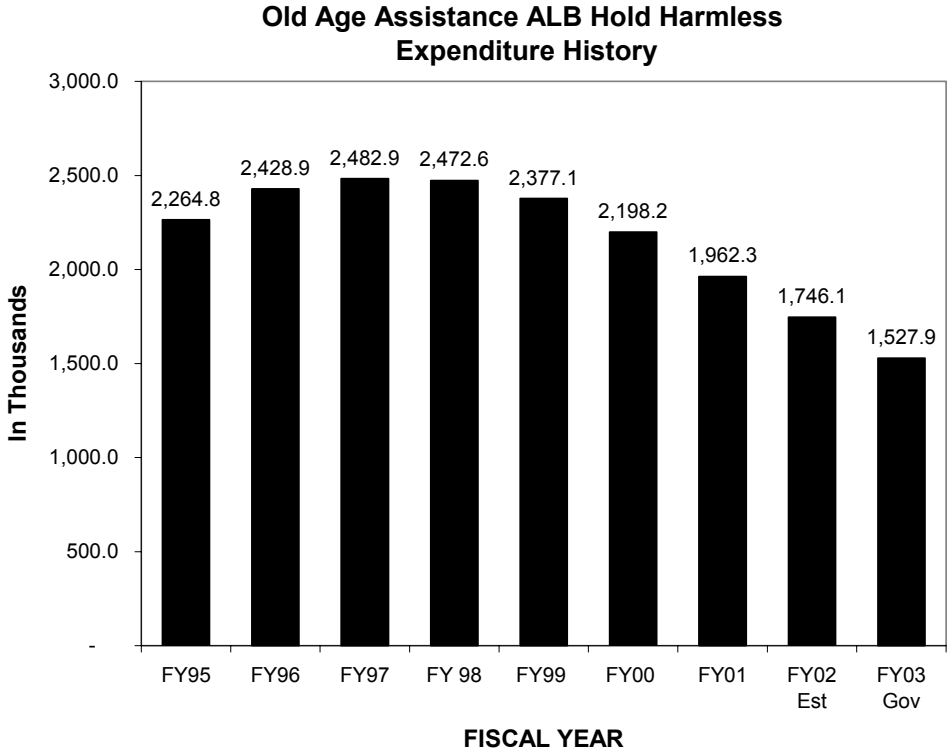
Within the APA population there are also individuals who, despite their disability, would like to work. However, lack of workplace accommodations, financial disincentives, and most notably, fear of the loss of Medicaid act as barriers to the goal of employment. Alaska has begun to address this problem by implementing the Working Disabled Medicaid option, which allows individuals whose earnings make them ineligible for traditional Medicaid to "buy-in" to the program by paying a premium. With this option many APA recipients can work, continue to receive critical health care, and contribute to their self-support.

The federal government has also addressed these issues with the passage of the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA). The Act established three grant programs designed to improve the capacity of State systems to support employment for people with disabilities. Alaska received these grants during FY 2001, a portion of which is being used to enhance services to APA recipients who wish to work. Four new positions have been established for the APA program – three Workforce Development Specialists who provide employment-focused case management, and one Training Specialist who specializes in training around disability issues. These positions, coupled with ongoing efforts to improve service delivery to working clients, are expanding the capacity of the APA program to promote employment and self-sufficiency.

DPA also continues to participate in the federally-funded Alaska Works Project, a five-year initiative designed to address the major barriers that keep people with disabilities from success in the workplace. Working collaboratively with the Governor's Council on Disabilities and Special Education and a consortium of state service providers, the project has begun to establish a coordinated and innovative service delivery system, and to eliminate barriers that prevent Alaskans with physical and mental disabilities from becoming competitively employed.

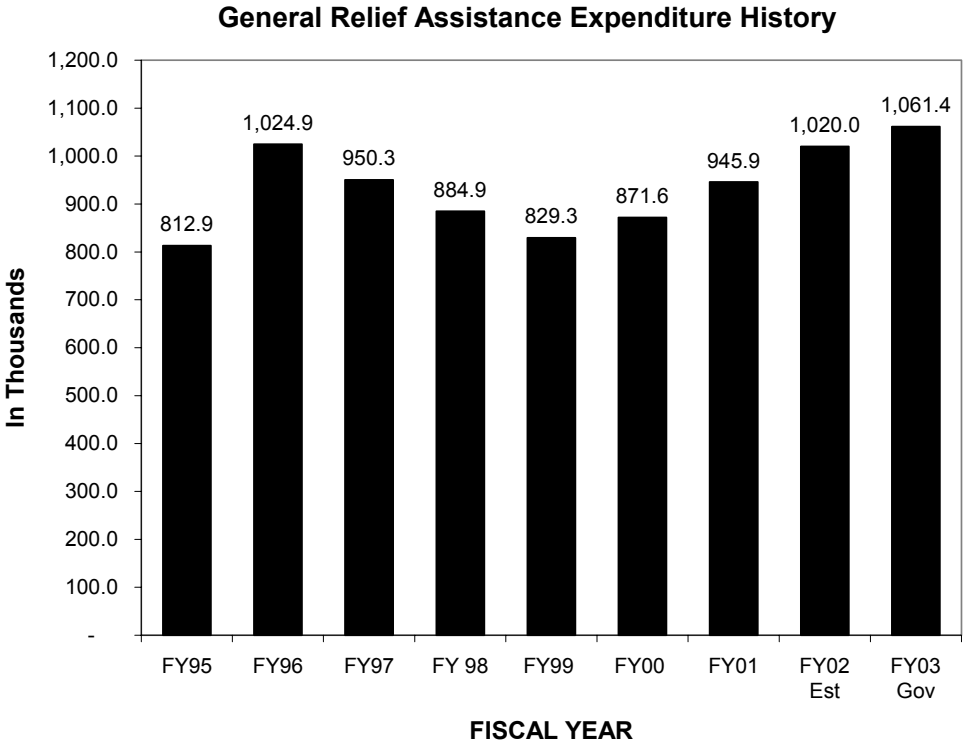
FY2003 Old Age Assistance-Alaska Longevity Bonus Hold Harmless component
Today approximately 1,250 aged clients receive OAA-ALBHH to replace the amount of federal Supplemental Security Income (SSI) lost when the ALB is counted as income in the SSI benefits calculation. The OAA-ALBHH restores the federal SSI payment reduction.

The ALB program is closed to new applicants and OAA-ALB Hold Harmless expenditures are continuing a sustained decrease as the number of APA and SSI recipients - who also receive the ALB - drops off. Based on the current expenditure trend we expect ALB Hold harmless expenditures will decline about 10-12% annually. In FY2003, the projected OAA-ALB HH program savings of $232.1 are transferred to the GRA component to help fund the projected formula need in the GRA program



FY2003 General Relief Assistance
Alaska's General Relief Assistance (GRA) program was developed as a safety net program for very low income individuals who are not eligible for other state or federal assistance. It is used as a last resort program to meet the emergency needs of low-income Alaskans who have no other resources available to meet those needs. Currently about 75 percent of GRA program expenditures are used to pay for funeral and burial expenses of indigent deceased persons. The remainder is used primarily to assist low-income individuals and families who are facing eviction.

In the last six years annual GRA program expenditures have ranged from a high of $1,024.9 in FY96 to a low of $829.9 in FY99. The FY03 GRA program expenditure is expected to be about $1.1 million. This budget request transfers projected FY2003 general fund savings of $232.1 GF from the OAA-ALB HH component to General Relief Assistance to fund formula GR need.



FY2003 PFD Hold Harmless

The FY2003 decrement of $3,139.4 adjusts PFD Hold Harmless component funding to projected formula need. The PFD Hold Harmless provides replacement funding for the loss of benefits due to client ineligibility or benefit reduction in the ATAP, Food Stamps, SSI, or Medicaid programs due to the receipt of the Alaska Permanent Fund Dividend.

The PFD Hold Harmless program is established in law as AS 43.34.075. The language establishing the hold harmless program was part of the legislation that enabled the initial 1982 dividend distribution, and continues as the statutory basis of the dividend and hold harmless programs.

The decrease in PFDHH represents the net reduction in public assistance formula caseloads and FY02 changes in budgeting method impacting hold harmless for food stamps. The division has changed the method for participant households to report changes in their circumstances. The new budgeting method estimates income "prospectively" to determine monthly benefit amounts. Rules of prospective budgeting permit us frequently to disregard the dividend. Hence, fewer households will get hold harmless benefits because they will now remain eligible for food stamps.

FY2003 Tribal Assistance Component
The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the federal welfare reform law) authorizes certain Alaska Regional native non-profit organizations, to administer Temporary Assistance for Needy Families (TANF) programs and to receive direct funding. In FY2000 the Legislature passed a bill authorizing four Native Organizations in Alaska to run Native TANF programs . The three organizations now running Native TANF programs are Tanana Chiefs Conference (TCC) in the interior Doyon region, Central Council of Tlingit & Haida Indian Tribes (T&H) in SE Alaska and Association of Village Council Presidents (AVCP) in the YK Delta.

Funding for Native Family Assistance program operation comes from the federal TANF block grant and supplemented by state funds that would otherwise be spent to serve the same Native welfare recipients. The FY2003 budget transfers $370.3 from the ATAP component to the Tribal Assistance component to reflect the approved actual grant plan in FY2002. State grant funding will be used for the purpose of providing temporary assistance benefits to eligible native families through the TCC, T&H and AVCP TANF programs.

FY2003 Public Assistance Field Services component
The recipients of public assistance, by definition, are living in poverty. With the advent of welfare reform, the Division has made a concerted effort to assist individuals and families toward self-sufficiency; to plan for the future, move off public assistance and leave poverty through employment. The Division's budget in recent years reflects a shift from direct financial assistance to child care and work services which help recipients find and retain employment. The early success of this approach has also yielded significant general fund savings.

While the ATAP caseload and expenditure have declined significantly, DPA continues to serve these working families by providing Food Stamps, Medicaid, and other employment related support services. Caseloads have grown in programs serving individuals for whom work is less likely. As Alaska's population has grown, so has the number of elderly and disabled persons needing safety net services, Adult Public Assistance (APA) and Medicaid.

FY2003 RSA funding increase for Denali KidCare Eligibility
An expansion of Medicaid in FY99, Denali KidCare, has helped more children from low-income working families obtain health insurance. Denali KidCare has contributed to the success of welfare reform because parents were reluctant to leave welfare for work for fear of losing health coverage for their children. Parents are now able to take a job that does not provide dependent health coverage.

This FY2003 budget adds $140.0 inter-agency receipt authority for the RSA with the Division of Medical Assistance that supports the Denali KidCare program. The Division of Public Assistance provides staff who determine eligibility, authorize benefits and assist Public Health staff with public program access. This change funds three Eligibility Technician I position to the Denali KidCare unit. These positions are needed to handle caseload work that reached 19,000 by July 2001. This increment aligns inter-agency receipt authority for full year funding supporting current and projected Denali KidCare program caseload.

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Division of Medical Assistance

Mission

The mission of the Division of Medical Assistance is to maintain access to health care and to provide health coverage for Alaskans in need.

Introduction

In keeping with its mission, the Division of Medical Assistance (DMA) is committed to providing Alaskans in need access to the same broad range of medical care and medical care providers available to the general population. To uphold its mission, the DMA provides the necessary inspection and surveillance to assure that the medical services provided are appropriate and of the proper amount, duration, and scope.

The DMA provides access to essential medical and medically related services through the State of Alaska's two primary health care programs: Medicaid and Chronic and Acute Medical Assistance (CAMA).

The Medicaid program is a jointly funded, cooperative venture between the federal and state governments that provides adequate and competent medical care to the state's most vulnerable populations. Medicaid is an entitlement program: if certain categorical low-income criteria are met, citizens are entitled to coverage of their medical needs. Within federal guidelines, the state establishes its own eligibility standards; determines the type, amount, duration and scope of services provided; sets the rate of payment for services; and administers its own program.

The Chronic and Acute Medical Assistance Program (CAMA) is a state-funded program that provides a strictly limited package of health services to those individuals with chronic medical conditions who do not qualify for Medicaid.

The Health Facilities Licensing & Certification (HFL&C) section is tasked with ensuring that Alaskans are provided safe health care in health facilities that meet quality standards.

The Medical Care Advisory Committee is mandated by federal law and provides valuable advice and support to the division and the department regarding medical programs. The DMA provides administrative and informational support to the committee.

The DMA processes 350,000 plus claims per month and is able to pay claims within an average of 11 days. DMA administrative costs remain under 4 percent of the total cost of medical services rendered. An emphasis on education and training for providers continues to be an important DMA goal as do third-party liability and recovery efforts -- all of which result in cost savings to the State.

The DMA recovery unit is responsible for recovering amounts from third-party payers when a Medicaid eligible individual has health insurance coverage available from another plan. Other significant areas of cost recovery include drug rebate and the Medicare Buy-in Program in which Medicaid pays Medicare premiums for those members who are also eligible for Medicare. In FY2001, DMA was able to recover more than $59 million.

Annual Statistical Summary of Services Provided in FY2001

		Medicaid	CAMA
Eligibles		118,062	1,704
Recipients		100,144	1,288
Eligibles by Race	White	42.8%	76.0%
	Native	36.9%	8.0%
	Other	7.5%	2.5%
	Black	5.2%	8.0%
	Asian	4.2%	2.8%
	Hispanic	3.4%	2.8%
Eligibles by Gender	Male	44.5%	54.0%
	Female	55.6%	46.0%
Eligibles by Age Group	>1	6.1%	-
	1 to 5	19.4%	-
	6 to 14	31.1%	-
	14 to 20	12.1%	1.0%
	21 to 44	17.6%	56.0%
	45 to 64	7.0%	43.0%
	65 to 74	3.7%	-
	75 to 84	2.4%	-
	85+	0.7%	-
Expenditures by	Hospital Services	$140,942,900	$822,200
Category of Service	Physician Services	$96,601,000	$1,464,900
	Waivers	$70,979,500	-
	Nursing Homes	$70,510,200	-
	Pharmacy	$54,973,400	$1,997,700
	Mental Health	$39,479,800	-
	All Other Services	$30,996,500	$19,700
	Transportation	$21,206,400	-
	Total Expenditures	**$525,689,700**	**$4,304,500**

Data Sources: DMA JUCE database; DMA Financial Services & Recovery Unit

NOTE: The Medicaid information provided in the above "Annual Statistical Summary of Services Provided in FY 2001" reflects expenditure information processed by the Medicaid Management Information System (MMIS) and DMA Financial Services and Recovery Unit. The total expenditure amount does not include Non-MMIS activities such as ProShare and will not capture state accounting system (AKSAS) adjustments. Therefore, the expenditure dollar amount will not equal FY 01 Actuals information provided in the "Fiscal Year 2002 Operating Budget" produced by the Legislative Finance Division.

List of Primary Programs and Statutory Responsibilities

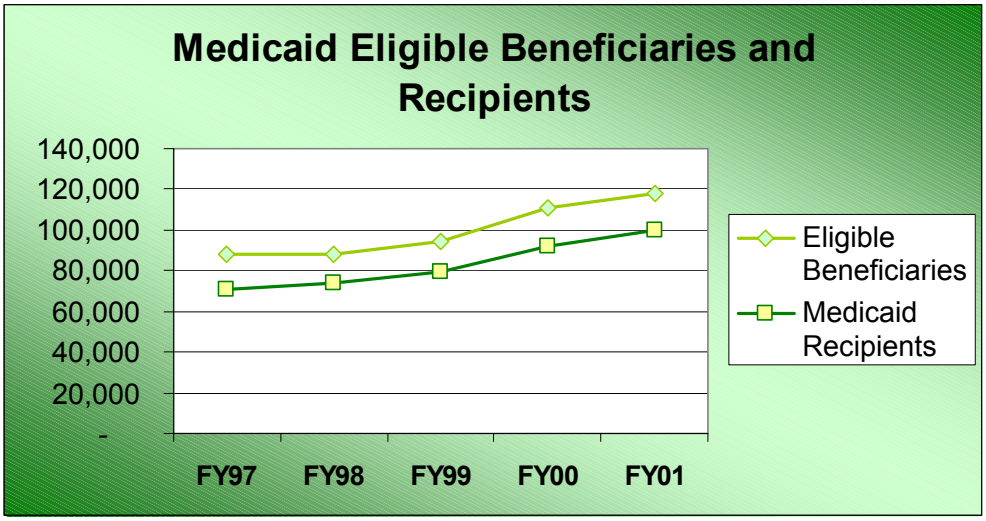
Many of the DMA's primary responsibilities are noted in the "Introduction" section of this overview. Those specifically tied to Alaska Statute are set out below.

AS 47.07 Medical Assistance for Needy Persons
Alaska's Medicaid Program was implemented in July 1972 and began as a program linked closely to eligibility for cash assistance programs for the very poor. It provided medical care to the aged, the blind, the disabled, and single parent families.

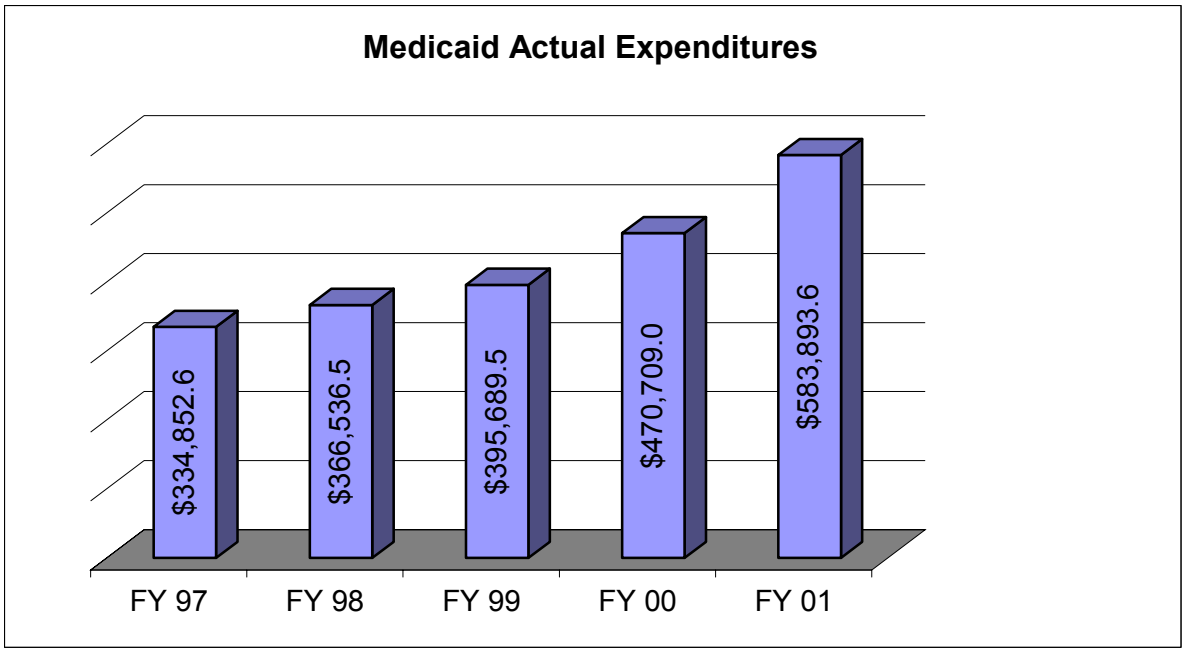
The program has since expanded and is now able to provide health care to eligible children and pregnant women, families with unemployed parents, and families who lose Medicaid eligibility because a parent has returned to work.

The following chart "Medicaid Eligible Beneficiaries and Recipients" provides a five-year look back at the Medicaid program's eligible beneficiary and recipient history. Medicaid currently provides health care coverage for one of every six Alaskans, and for the majority of these citizens, Medicaid is the only available health care coverage.

Date Source: DMA annual reports.



Medicaid expenditures continue to rise in Alaska in keeping with the nation-wide trend. On average, the program has grown 17 percent annually since FY1999.



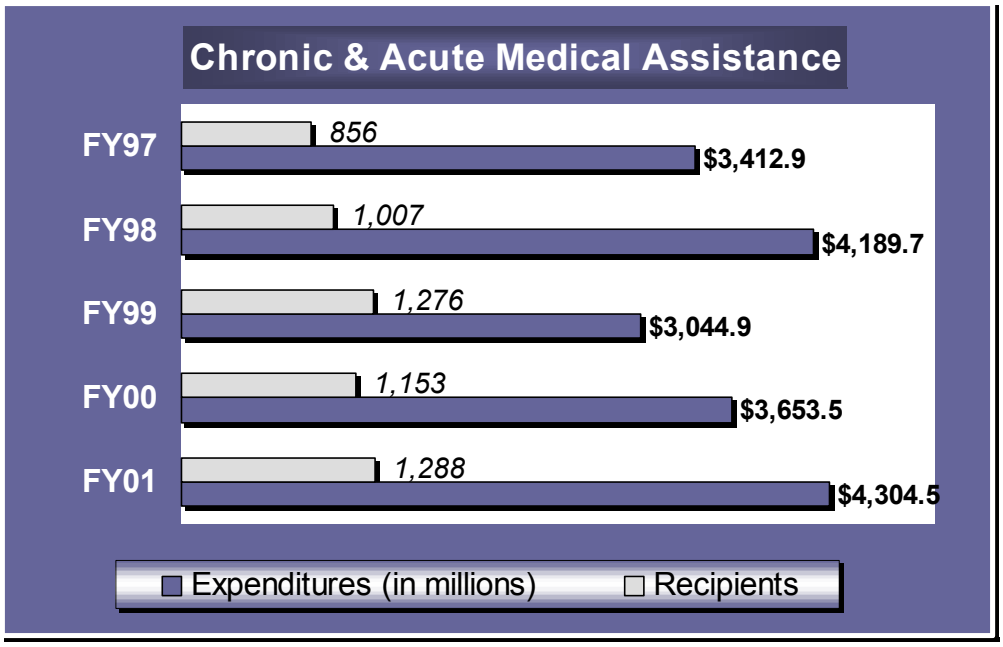
Services provided to Medicaid clients include those that are mandatory under federal law (Sec. 1905, Social Security Act) and those that are optional and identified by the State as those included in the state plan (AS 47.07.030).

AS 47.08 Assistance for Catastrophic Illness and Chronic or Acute Medical Conditions
The Chronic and Acute Medical Assistance Program (CAMA) was implemented July 1, 1999, replacing the General Relief Medical program. CAMA is funded entirely by State general fund dollars. CAMA provides a limited package of health services to those individuals with chronic medical conditions who do not qualify for the Medicaid program.

Persons who receive CAMA benefits must have an immediate need for health care, meet stringent income standards of less than $300 per month with total resources of less than $500 (with the exception of a home and a vehicle), and be unable to obtain any other private or public assistance. The only services allowable under the program are:

- Major medical inpatient hospital care (limit 8 days per year);
- Nursing home care and related lab and x-ray services;
- Transportation necessary for a hospital admission or nursing home care;
- Physician visits related to hospital admission and drug coverage (limit 12 visits per year);
- Drugs and prescribed medical supplies for individuals with terminal illnesses, undergoing chemotherapy, or who have one of four chronic illnesses: diabetes, seizure disorder, chronic mental illness, and hypertension.

The following chart "Chronic & Acute Medical Assistance" provides an historical recap of CAMA recipient numbers and expenditures per fiscal year for the past five years.

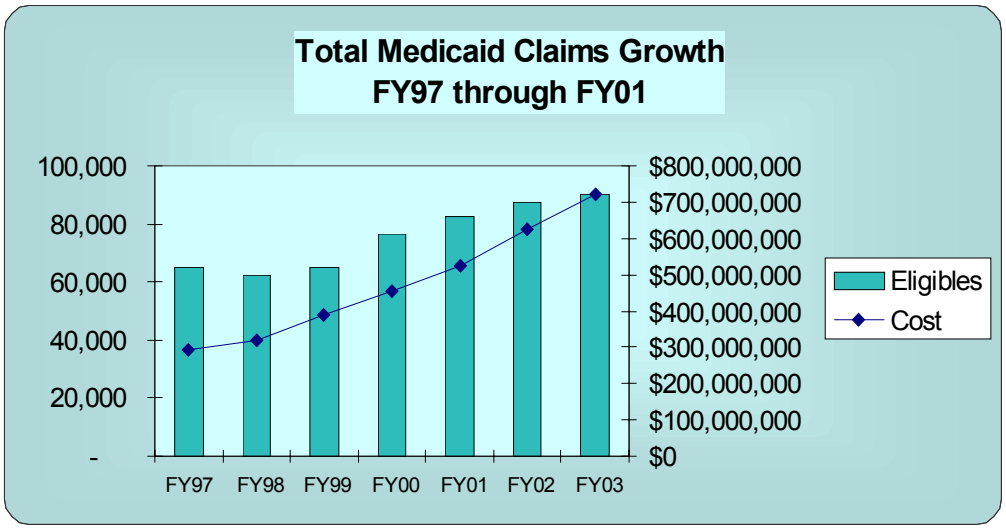


Data Source: DMA Annual Reports

Medicaid Program Growth
The method used to calculate Medicaid funding need begins with a basic formula to determine, retrospectively to 1996, the average cost per member per month for each individual Medicaid beneficiary group: Children, Adults, the Elderly, and the Disabled. The average of each group's historical number of members per month and the average cost of services provided to each member per month is determined.

Projections are further developed through a separate analysis of the variable factors that affect Medicaid program enrollment and costs. The division takes into consideration anticipated changes in state and federal policy and in the related social and economic environment that will likely influence the number of eligible members enrolled and/or the cost of services provided to each individual member group. It should be noted that the DMA has made no adjustments to FY2003 budget projections in anticipation of the potential impact of the events of September 11, 2001.

This chart ("Total Medicaid Claims Growth FY97 through FY01") exhibits Alaska's Medicaid historical and projected claims payment growth from FY97 through FY03. The Medicaid program actual rate of growth has averaged 17.8 percent for FY1999, FY2000, and FY2001. This rate drops to 15 percent for the period FY1998 through FY2001.



Medicaid Eligible Growth
Eligible growth for FY1999 to FY2001 has averaged about 8 percent and varies significantly between eligible groups. It is expected that eligible numbers as a whole will level and possibly decline slightly throughout FY2003 as increased participation resulting from relatively recent program enhancements reach maximum saturation.

Children
Medicaid, through Title XIX and Alaska's Title XXI Children's Health Insurance Program expansion (Denali KidCare), was able to make essential medical care services available to an average of 54,600 children each month during FY2001 for an approximate cost of $185.5 million. In FY2003, the average number of children enrolled in the program on a monthly basis is projected to reach 61,500 at

a cost of $255.6 million. This represents a significant slowing and leveling of eligible numbers growth throughout FY2002 and FY2003 with costs projected to increase at just below the 3-year average program growth rate. Children, on an individual average basis, are Alaska's least expensive member group.

Adults

Eligible numbers for adults have shown a steady, slow decline from FY1999 through FY2001 and may fall to 12,000 by FY2003. This is, at least in part, due to enrollees that drop from the program under welfare-to-work. It can be assumed that the adult population remaining on the program includes those that will need more costly care, including pregnant women and adults with more serious health problems. Projections indicate a minimal increase in costs -- even though eligible numbers are decreasing. Total projected FY 2003 cost for Medicaid eligible adults is $90.0 million.

Elderly

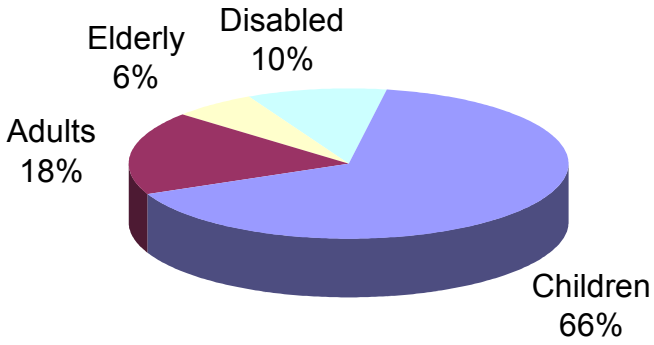
Alaska's elderly population has, in the past, been the most predictable eligible group. The growth rate for the average monthly number of enrolled has remained in the 3 to 4 percent range since FY1999. The FY2003 growth rate is expected to remain the same and has been projected at approximately 3 percent for a total of 6,000 eligible elderly persons. Costs are projected to grow at a very conservative rate of about 2 percent to a total projected cost of $101.4 million.

Disabled

Alaska's disabled population, similar to the elderly, has remained fairly stable since FY1999 with eligible growth rates in the 5 to 7 percent range. FY2003 projections indicate the program could provide services to approximately 11,000 enrollees at a cost of $262.6 million. The disabled are the most expensive members of Medicaid.

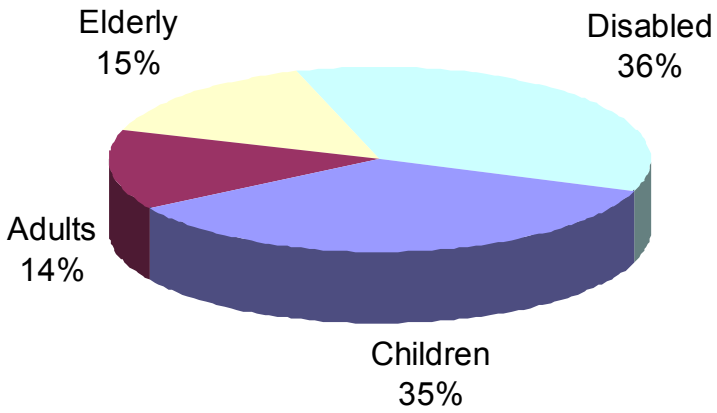
The "Medicaid Eligibles by Group" and "Medicaid Expenditures by Eligible Recipient Group" charts below provide a good visual aid that distributes Medicaid eligibles and the claims payment expenditures attributed to each.

Medicaid Eligibles by Group



The disabled category in both charts includes both children (1.5 percent of the eligibles an 6 percent of the expenditures) and adults (8.5 percent of the eligibles and 30 percent of the expenditures).

Medicaid Expenditures by Eligible Recipient Group



Children account for 67.5 percent of all Medicaid "eligibles" and 41 percent of all expenditures. These statistics have changed very little over the past several years.

The following table provides statistical data about Alaska's Medicaid eligible population. It displays the average number of eligibles per group per month and the average cost per eligible per month within each group. Also included are FY2002 authorized numbers and FY2003 projections.

Average Number of Eligible Recipients Monthly

	Children	Adults	Elderly	Disabled	Totals
FY97	37,665	14,332	4,843	7,949	64,790
FY98	36,114	13,196	4,923	8,159	62,391
FY99	38,001	13,333	5,062	8,755	65,151
FY00	49,155	12,990	5,268	9,251	76,664
FY01	54,602	12,445	5,426	9,801	82,274

Change In Average Number of Eligible Recipients Monthly

	Children	Adults	Elderly	Disabled	Totals
FY97					
FY98	(1,552)	(1,136)	80	209	(2,398)
FY99	1,887	137	139	596	2,760
FY00	11,154	(343)	206	496	11,513
FY01	5,448	(545)	158	550	5,610

Average Monthly Cost Per Eligible Recipient

	Children	Adults	Elderly	Disabled	Totals
FY97	$207.55	$282.47	$876.94	$1,059.60	$378.70
FY98	$234.52	$329.75	$947.75	$1,181.30	$434.75
FY99	$272.65	$372.87	$1,041.52	$1,285.83	$489.04
FY00	$262.14	$424.81	$1,129.36	$1,417.49	$488.71
FY01	$283.05	$473.33	$1,209.33	$1,623.54	$532.61

Change In Average Monthly Cost Per Eligible Recipient

	Children	Adults	Elderly	Disabled	Totals
FY97					
FY98	$26.97	$47.28	$70.80	$121.70	$56.05
FY99	$38.12	$43.12	$93.77	$104.52	$54.30
FY00	($10.50)	$51.94	$87.83	$131.67	($0.33)
FY01	$20.91	$48.52	$79.97	$206.05	$43.90

Medicaid Expenditure Growth

Claims payments grew by approximately 13 percent between FY2000 and FY2001. This amounts to a total of $58.3 million. Medicaid's total budget increased by $113.2 million. The difference between these two increases is attributed to Medicaid activities that are unrelated to claims processed through the Medicaid Management Information System. These activities include, but are not limited to, disproportionate share hospital payments, public health nursing reimbursable services, and ProShare.

The DMA anticipates claims payment growth from FY2002 to FY2003 will reach 16 percent for total claims payments of about $723 million. Approximately 25 percent of this growth in expenditures may be attributed to eligible growth, the remaining growth is attributed to increased utilization and increased health care costs.

The charts below set out Medicaid's 10 fastest growing expenditure categories of service and those that represent the top 10 expense categories.

FY01 Top Expenditure Categories of Services	
Hospital Services	$128,929,284
Physician Services	$96,600,954
Pharmacy	$54,973,432
Nursing Homes	$46,975,802
MRDD Waivers*	$42,377,562
Mental Health	$39,479,765
Medicaid Other Services	$28,551,246
Residential Psychiatric Treatment Centers	$23,611,943
Transportation	$21,206,322
Older Alaskans Waiver	$14,723,800

*Mental Retardation and Developmental Disabilities

Fastest Growing Categories of Service (3-Year Average)	
Adults with Physical Disabilities Waiver	81%
Residential Psychiatric Treatment Centers	78%
CCMC Waiver**	51%
MRDD Waiver*	41%
Older Alaskans Waiver	31%
Transportation	23%
Pharmacy	21%
Physician Services	20%
Psychiatric Hospitals	18%
Nursing Homes	4%

** Children with Complex Medical Conditions

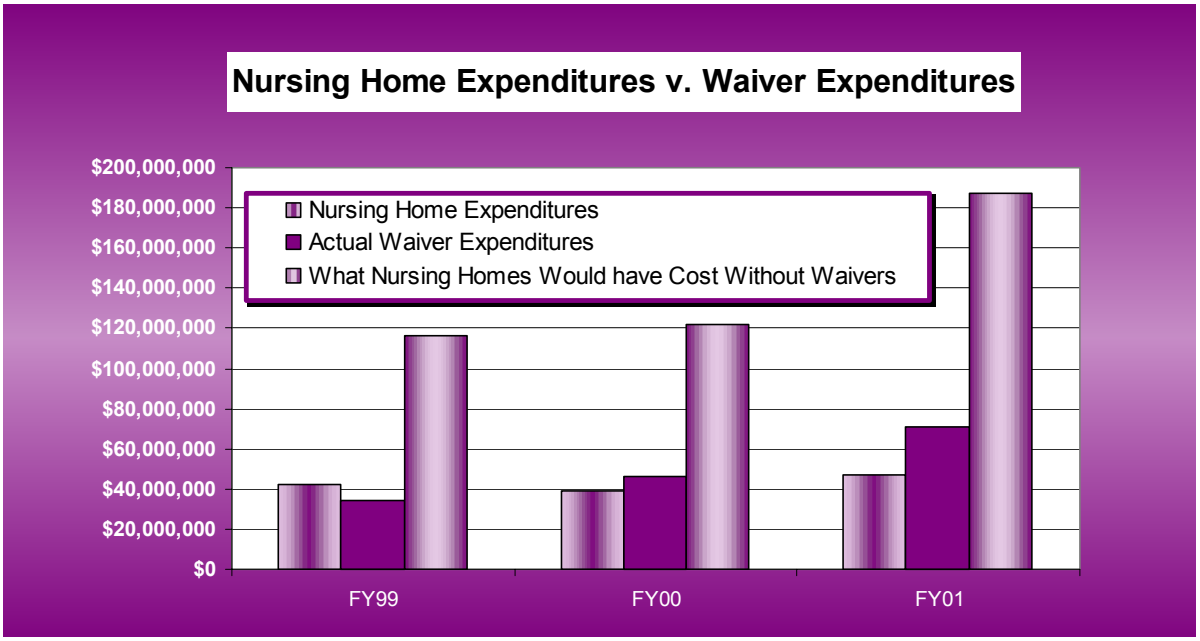
Date Source: DMA JUCE Database;
DMA Financial Services & Recovery

Home & Community Based Care Services (Waivers)

Expenditures for waiver services totaled $70.9 million in FY2001. There are four waiver types: Adults with Physical Disabilities (APD), Children with Complex Medical Conditions (CCMC), Mental Retardation and Developmental Disabilities (MRDD), and Older Alaskans (OA). Waivers allow persons in need of institutional-level care to live in their home and community rather than in an institution. The cost of these services must be no more than the aggregate cost of the otherwise required institutional services.

The DMA, working with the Divisions of Senior Services and Mental Health and Developmental Disabilities, has made it a priority to offer Medicaid recipients this non-institutional alternative to nursing homes and intermediate care facilities for the mentally retarded. Alaskan providers have also continued to develop and expand the capacity of home and community based services.

The chart "Nursing Home Expenditures v. Waiver Expenditures" provides a comparison of actual nursing home costs and waiver costs. It also provides a visual guide as to what nursing homes could have cost without waivers.



Medicaid Increment Summary

FY2003 Medicaid Services Increment Breakout

	GF
Original FY 2003 Growth Increment Request	**$93,544.0**
FMAP Statutory Reduction (a)	**-$10,797.2**
Public Hospital ProShare (b)	**$18,733.7**
AK Medicaid Fair-Share Program (c)	**-$44,296.7**
Private Hospital Refinancing (c)	**-$11,840.0**
Net Increase in FY 2003 General Fund Request	**$26,610.1**

(a) Not included in FY 2003 budget request, assumes Congressional fix
(b) ProShare federally required reduction
(c) Assumes federal approval

Innovative options for refinancing have been researched and incorporated into the Medicaid incremental request. The budget also assumes that a Congressional "fix" to increase Alaska's FMAP will be forthcoming. The refinancing options and the anticipated increase in FMAP helps reduce the Medicaid general fund request.

Alaska Medicaid Fair-Share Program
This proposed program is an extension of the Hospital ProShare Program to Tribal hospitals, which were not excluded from federal regulations restricting ProShare from community hospitals. In this arrangement, the DMA will make an additional payment for services to Medicaid-eligible

beneficiaries to hospitals operated by Alaskan Tribes, up to the payment limit applicable. The hospitals will return 90 percent of the payment to the Medicaid Program as statutory designated program receipts that can be used as match for Medicaid service payments. The result is a net savings of $44.3 million in general fund requirements for Medicaid.

Private Hospital Refinancing
Private hospital refinancing options are being considered. The division will make additional payments of $31.7 million to private hospitals up to the aggregate Medicare Upper Payment Limit. The hospitals will retain 5 percent of the payment to pay for state-funded programs previously paid for with direct state grants or contracts. It is anticipated that up to 95 percent of the funds made available, $11.8 million, will be appropriated to the Medicaid Services BRU to cover state match requirements.

Federal Funding Policy Changes
The Federal Medical Assistance Percentage (FMAP) rate was decreased to 57.38 percent for federal fiscal year 2002. Early federal estimates indicate federal fiscal year 2003 will increase slightly to 58.22 percent. These changes are significant and carry with them a projected loss of $10.8 million in federal fund participation. The Department and the DMA have prepared this incremental request in anticipation of a Congressional "fix" for FMAP that may be included in congressional legislation responding to the events of September 11, 2001.

Division of Family & Youth Services

Mission

To protect children who are abused and neglected or at risk of abuse and neglect.

Introduction

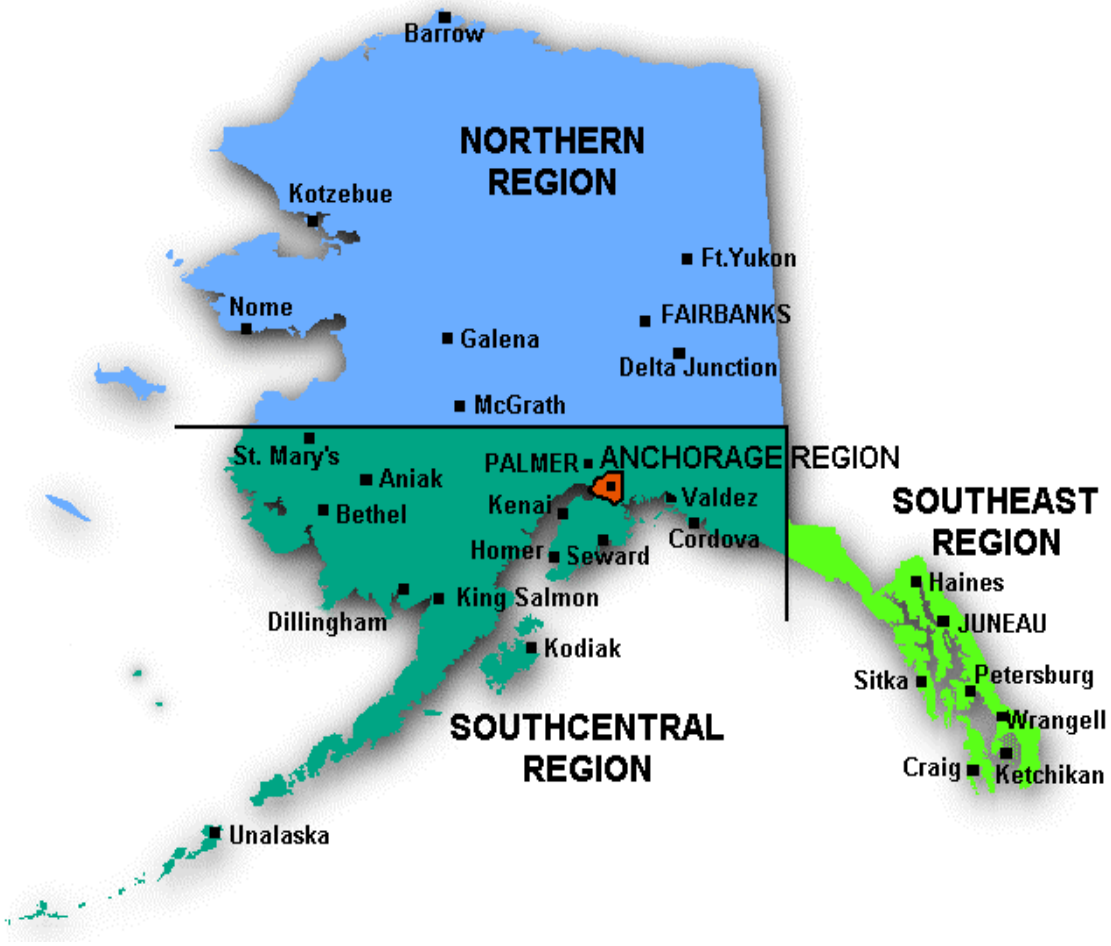
To meet this mission, the Division of Family and Youth Services (DFYS) provides child protective services, permanency planning for children, community care licensing, foster and residential care, family support services, and subsidized adoption and guardianship for special needs children.

The role of the state's child protection agency includes the following.

- To receive and assess allegations of abuse and neglect;
- To assess the risk and safety to the child, and evaluate the family's ability to accept and use help;
- To initiate court involvement for both the removal of children and the provision of mandatory protective services;
- To provide permanency planning for children and coordinate resources for the family;
- To assure that children are receiving a minimum standard of care before closing a case, although the state's involvement should be goal-focused and time-limited;
- To educate the public regarding what is reportable, and to develop and coordinate community resources and services.

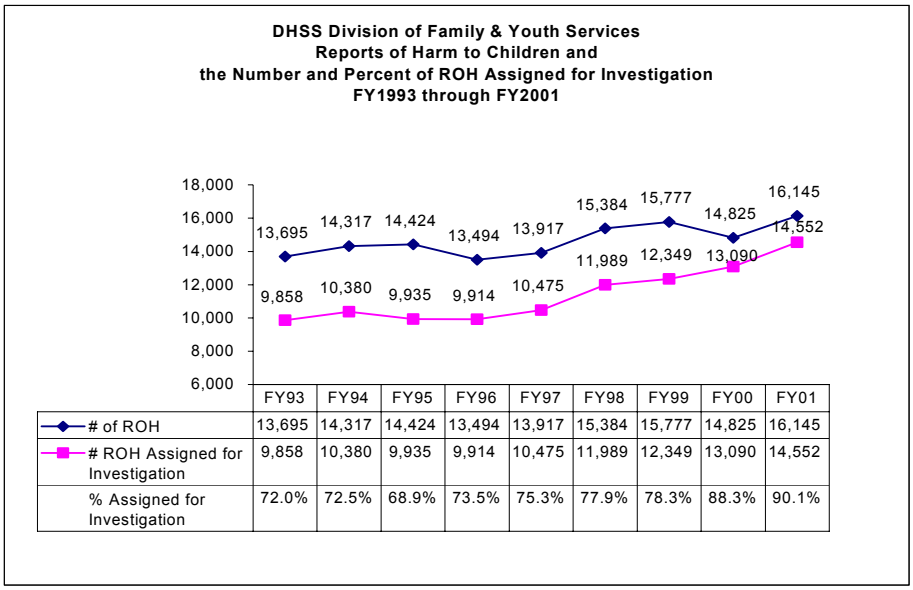
As shown in the following chart, DFYS is organized in four regions and has 29 field offices. The Northern Regional Office (NRO) is located in Fairbanks and is responsible for Nome, Kotzebue, Barrow, and surrounding towns and villages. The South-central Regional Office (SCRO) is located in Mat-Su and is responsible for the Mat-Su Valley, the Kenai Peninsula, Bethel, Valdez, Kodiak, Dillingham, the Aleutian Islands, and surrounding areas. The Anchorage Regional Office (ARO) is located in Anchorage and is responsible for Anchorage. The Southeastern Regional Office (SERO) is in Juneau and is responsible for Juneau, Haines, Sitka, Petersburg, Ketchikan and surrounding communities.

Department of Health and Social Services
Division of Family and Youth Services Offices



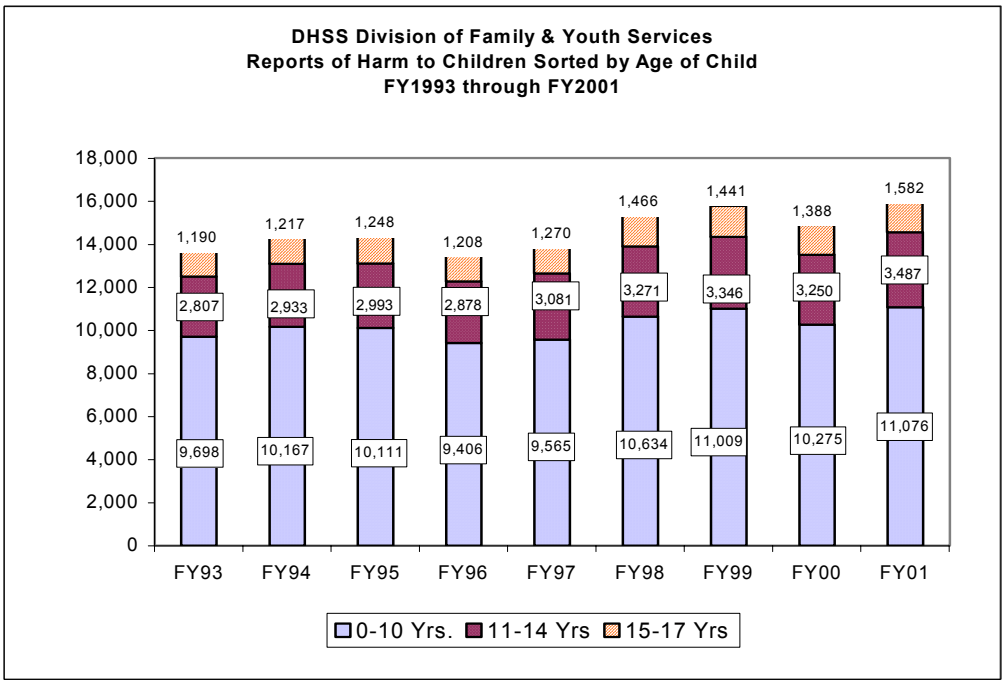
Reports of Harm

DFYS receives and responds to reports of harm (ROH) on children. The following three charts present ROH caseload and demographic data. Chart #1 shows the number of ROH's received by DFYS and the number of ROH's Assigned for Investigation from FY1993 through FY2001. As the chart indicates, the overall number and percentage of ROH assigned for investigations has increased steadily over the past several years.



	FY93	FY94	FY95	FY96	FY97	FY98	FY99	FY00	FY01
# of ROH	13,695	14,317	14,424	13,494	13,917	15,384	15,777	14,825	16,145
# ROH Assigned for Investigation	9,858	10,380	9,935	9,914	10,475	11,989	12,349	13,090	14,552
% Assigned for Investigation	72.0%	72.5%	68.9%	73.5%	75.3%	77.9%	78.3%	88.3%	90.1%

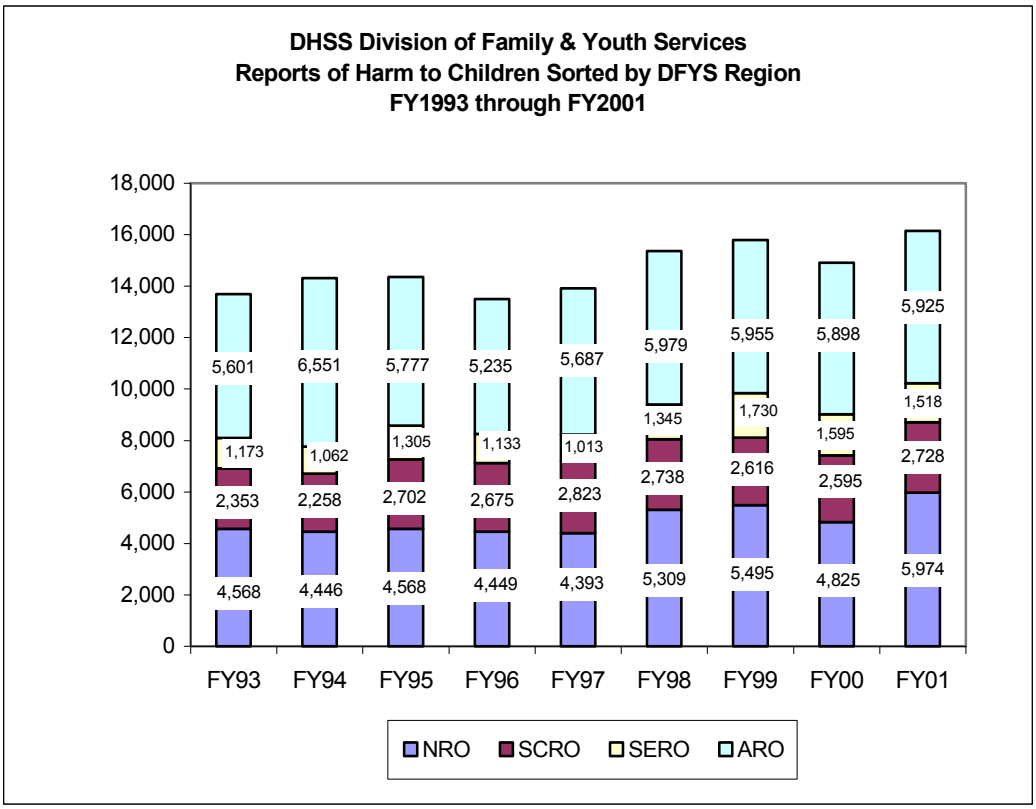
The next chart shows the number of ROH received by age of child from FY1993 to FY2001. Note that in all years, the preponderance of the reports of harm were on children age 10 years and younger. The table immediately following shows the percentage of ROH by age. Note that in all years, children ages 0 to 10 made up over 68% of the children reported.



Percent of Child Reports of Harm by Age

	0-10 Yrs	11-14 Yrs	15-17 Yrs	Total
FY93	70.8%	20.5%	8.7%	100.0%
FY94	71.0%	20.5%	8.5%	100.0%
FY95	70.5%	20.9%	8.7%	100.0%
FY96	69.7%	21.3%	9.0%	100.0%
FY97	68.7%	22.1%	9.1%	100.0%
FY98	69.2%	21.3%	9.5%	100.0%
FY99	69.7%	21.2%	9.1%	100.0%
FY00	68.9%	21.8%	9.3%	100.0%
FY01	68.6%	21.6%	9.8%	100.0%

The following chart shows the number of ROH reported to DFYS in each of the four DFYS Regions from FY1993 to FY2001. During this nine-year period the average distribution of reports of harm was as follows: Northern Region 33.3%; Southcentral Region 17.8%; Southeast Region 9.0%; and Anchorage Region 39.9%.



The Anchorage Region (ARO) includes all of the Anchorage area. The Southeast Region (SERO) includes Haines, Sitka, Petersburg, Ketchikan, Juneau and surrounding communities. The Southcentral Regional (SCRO) includes the Mat-Su Valley, the Kenai Peninsula, Bethel, Valdez, Kodiak, Dillingham, the Aleutian Islands, and surrounding areas. The Northern Regional (NRO) includes Fairbanks, Nome, Kotzebue, Barrow, and surrounding towns and villages.

The following table shows the percentage of ROH received by the four DFYS Regions during this period.

	NRO	SCRO	SERO	ARO
FY93	33.40%	17.20%	8.60%	40.90%
FY94	31.10%	15.80%	7.40%	45.80%
FY95	31.80%	18.80%	9.10%	40.30%
FY96	33.00%	19.80%	8.40%	38.80%
FY97	31.60%	20.30%	7.30%	40.90%
FY98	34.50%	17.80%	8.80%	38.90%
FY99	34.80%	16.60%	11.00%	37.70%
FY00	32.40%	17.40%	10.70%	39.50%
FY01	37.00%	16.90%	9.40%	36.70%
Average:	33.30%	17.80%	9.00%	39.90%

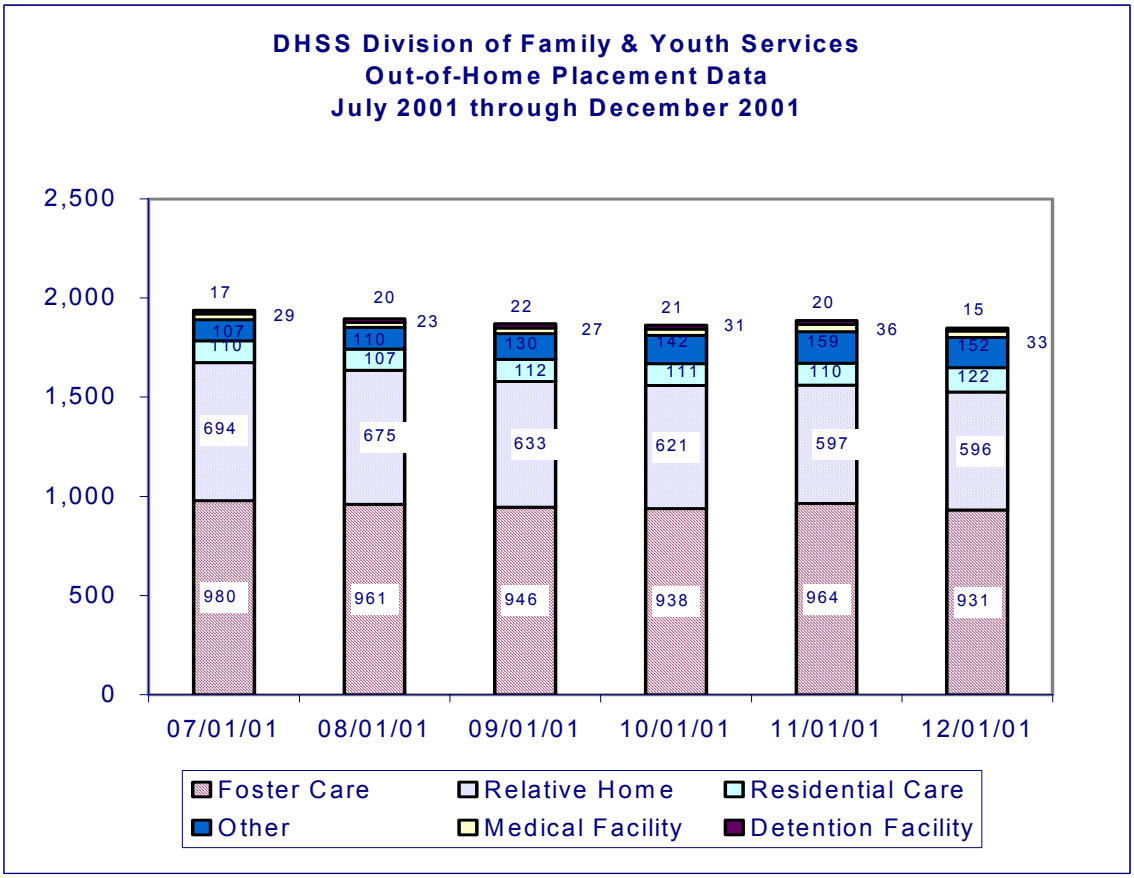
Note: Minor difference in monthly totals of the numbers of ROH between the three charts is due to timing differences of data extraction from the Division's client management information system.

Children in Out-of-Home Care by Placement Category

The following table shows a breakdown of children in out-of-home placements for the period July 2001 through December 2001. Placement categories include foster care, relative home, residential care, medical facility, and detention/correction facility. During this period, approximately one-half of children in out-of-home placements were in foster care and approximately one-third were in relative homes.

Placement	7/1/01		8/1/01		9/1/01		10/1/01		11/1/01		12/1/01	
Relative Home	694	35.8%	675	35.6%	633	33.9%	621	33.3%	597	31.7%	596	32.2%
Foster Care	980	50.6%	961	50.7%	946	50.6%	938	50.3%	964	51.1%	931	50.4%
Medical Facility	29	1.5%	23	1.2%	27	1.4%	31	1.7%	36	1.9%	33	1.8%
Residential Care	110	5.7%	107	5.6%	112	6.0%	111	6.0%	110	5.8%	122	6.6%
Detention Facility	17	0.9%	20	1.1%	22	1.2%	21	1.1%	20	1.1%	15	0.8%
Other	107	5.5%	110	5.8%	130	7.0%	142	7.6%	159	8.4%	152	8.2%
Total:	1,937	100.0%	1,896	100.0%	1,870	100.0%	1,864	100.0%	1,886	100.0%	1,849	100.0%

Out-of-home Placement Data for July 1, 2001 through December 1, 2001 is shown in the following chart:



List of Primary Programs and Statutory Responsibilities

Child and Welfare AS 47.10
The Division directly provides and uses grants to community non-profit agencies to provide the following services to meet the mandates of Alaska's child protection and child welfare statutes (AS 47.10). These statutes state that the Department shall "arrange for the care of every child committed to its custody" and "pay the costs necessary to ensure adequate care of the child."

Child Protective Services
For FY2002 the Division through the Front Line Social Workers component maintains approximately 333 permanent positions, including 241 social workers and social services associates, located in four regional offices and twenty-nine field offices spanning from Ketchikan to Barrow to deliver direct services to abused and neglected children and their families. The front line workers receive reports of harm on children throughout the state, assess the risk and safety to the child by conducting an investigation, and determine whether the child has been harmed and will continue to be harmed if left without intervention.

Permanency Planning for Children
The division employees conduct a comprehensive case planning process directed toward the goal of a permanent, stable home for every child. These case planning activities are directed toward assuring that every child in the state's care has a permanent family, capable of providing them with nurturance and protection. When this is not the child's family, then an alternate permanent family is found for the child. In accordance with State and Federal law, the Division administers the Subsidized Adoption & Guardianship program to place eligible children in permanent homes. To assist in this effort, the Division utilizes grants to non-profit community service agencies to perform adoption home studies.

Community Care Licensing
DFYS maintains 16 Community Care Licensing Specialist positions that conduct home studies for approximately 1,220 licensed foster homes, 55 residential care providers, and 14 child placement agencies. The Division's social workers also perform licensing functions in field offices where no Community Care Licensing Specialist has been assigned. Community Care Licensing reduces predictable risk by regulating the care of vulnerable children. Once a home, center, or agency is licensed, then Community Care Licensing workers are responsible for monitoring the continual compliance to safety measures.

Foster Care AS 47.14.100
AS 47.14.100 mandates the Department to provide for the "…care of every child committed to its custody by placing the child in a foster home or in the care of an agency or institution providing care for children inside or outside the state." To meet this mandate, DFYS administers four foster care programs including Foster Care Base Rate, Foster Care Augmented, Foster Care Special Needs, and

Foster Care AYI (Alaska Youth Initiative) for children in State custody. These are children that have been removed from situations of abuse or neglect and are at risk for further abuse and neglect. When these children cannot be safely maintained in their own home, it is much better for them to be placed in a foster home.

Foster Care Base Rate
The Foster Care Base Rate program is designed to reimburse foster parents for the basic ongoing costs of raising a child including food, clothing replacement, and shelter.

Foster Care Augmented
The Augmented Foster Care program reimburses foster care providers for extraordinary costs and for higher levels of supervision not otherwise covered by the Foster Care Base Rate program.

Foster Care Special Needs
The Foster Care Special Needs program is designed to reimburse foster care providers for "one-time" or "irregular" expenses authorized by AS 47.14 that are not covered by the Foster Care Base Rate or are not being paid by the Foster Care Augmented program.

Subsidized Adoption & Guardianship AS 25.23 and AS 47.10
The Subsidized Adoption & Guardianship program is an adoption incentive program for children with special needs. This program transitions children from foster care into permanent homes. The subsidy payment covers the cost of the child's special needs and is available to the family until the child reaches age 18.

Residential Care
For FY2002 the Department has purchased approximately 312 residential treatment beds through community grants. These grants provide a continuum of five levels of residential treatment ranging from day treatment to residential psychiatric treatment center services for children in DFYS and Division of Juvenile Justice (DJJ) custody. The current foster care system is overcrowded with many foster care children that experience severe emotional and behavioral problems. These children often fail in foster home settings, resulting in multiple placements and often the loss of foster homes. For many of these children, group care, a treatment environment with 24-hour professional staff, is a more appropriate placement.

The Department also established a system for obtaining Medicaid funds for residential care services, which are matched with existing general funds. This accomplishes two primary objectives. One, residential care providers are required to improve treatment services, and, two, the new funding mechanism will provide the residential care providers with funds to implement these improvements and to maintain sufficient staffing levels.

Family Support Services
The Division uses Federal and State funds to provide 31 Family Support, Family Preservation, and Time Limited Family Reunification grants to 26 non-profit grantees statewide. These grantees provide family-based services to division-referred children and families.

Family and Youth Services Management
The primary purpose of the Family and Youth Services Management component is to provide comprehensive technical, managerial and financial support to the front line social workers located in four regions in twenty-nine field offices throughout the state.

Family & Youth Services Staff Training
The Family and Youth Services Staff Training Academy, through an agreement with the University of Alaska, provides education and training for DFYS social workers, social services associates, licensing workers, supervisors and managers to enhance their ability to recognize abuse and neglect, to increase their skills in working with children and their families.

Balloon Project

Continuation of the Balloon Project efforts through the Adoption Placement Program:
State and Federal law requires children that have been in foster care for 15 of the past consecutive 22 months to be placed into permanent homes. The Adoption Placement Program (formerly the Balloon Project) is a collaborative program that provides funding for DFYS and partner legal agencies including the Department of Law, the Public Defender Agency and the Office of Public Advocacy to focus on moving children on the "transition list" that have been in custody the longest from the foster care system into permanent placements. One measure of the program's success can be seen in the leveling off of the growth of the Department's foster care caseload. The foster care caseload increased by 16.8% in FY1998 and 16.4% in FY1999 compared to only 5.8% in FY2000. In FY2001 the foster care caseload decreased 6.2%. The Department expects the foster care caseload to remain steady for FY2002 and FY2003.

Long-term benefits of the Adoption Placement Program include permanent homes for children; savings from reduced foster care caseloads; increased compliance with Federal and State laws; prevention of case backlogs from happening again; continued collaboration between DFYS and the State legal entities to process child protective services cases on a timely basis; and more efficient operations.

The Adoption Placement Program initially targeted a backlog of 661 children who had been living in out-of-home placements for 15 of the previous 22 months as of November 19, 1997. So far, 90 percent of the original 661 children have achieved permanency. Permanency includes returning home to parents; aging out/emancipation; leaving for adoption or guardianship; entering the juvenile justice system; staying in long-term foster care (with a compelling reason not to terminate parental rights); and returning home to parents under supervised stated custody.

As shown in the following table, Phases II and III of the Adoption Placement Program were implemented in January 2000, Phase IV implemented September 2000 and Phase V September 2001. Note that all phases of the Balloon project are made of unique cohorts of children.

	Implementation Date	**Number of Months Child in** Out-of-Home Care	**Number of Children**
Phase I:	July 1999	15 out of the past 22 months as of 11/19/97	661
Phase II:	January 2000	38+ months as of January 2000	43
Phase III:	January 2000	27-38 months as of January 2000	373
Phase IV:	September 2000	24+ months as of July 2000	367
Phase V:	September 2001	24+ months as of April 2001	186
			1630

The following table shows the number of children in Phases I through V of the Adoption Placement Program that have achieved permanency as of December 15, 2001.

Summary of Adoption Placement Program
Achieving Permanency

Phases I, II, III, IV and V as of December 15, 2001

	Phase I	Phase II	Phase III	Phase IV	Phase V	Total
Released to Parents	158	9	113	74	0	354
Aged Out/Emancipated	85	2	13	12	1	113
Adopted	219	14	96	72	13	414
Guardianship	102	3	46	41	7	199
Juvenile Justice System	2	0	0	1	2	5
LTFC/Compelling Reason	26	2	13	15	6	62
Returned home but still under state custody	4	3	20	18	13	58
	596	33	301	233	42	1205

Funding for Continuation of the Adoption Placement Program

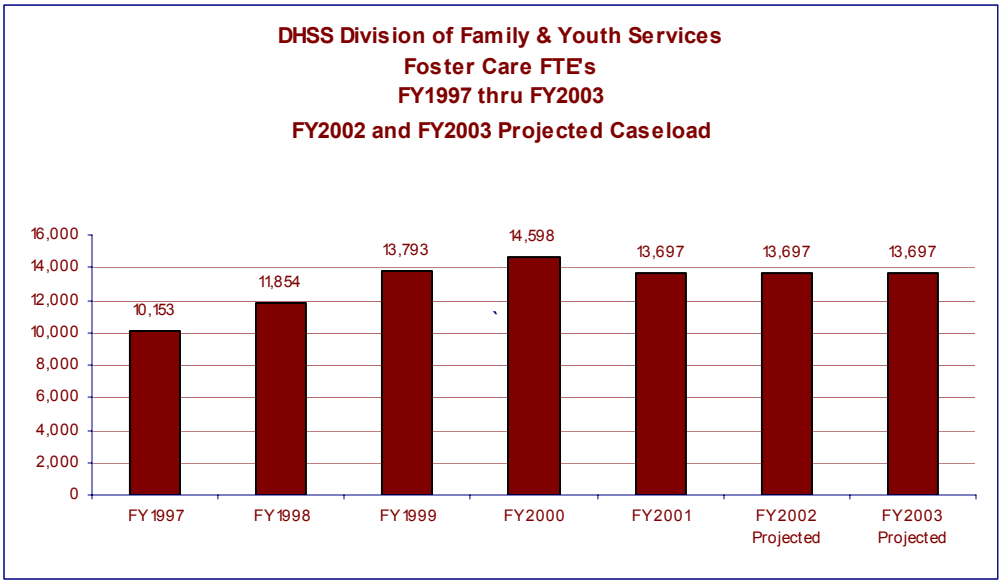
The Department's FY2003 budget includes provisions for continued implementation of the systems set in place by the Balloon Project. Continuation of this effort is critical to assure that every child in state custody receives timely case plans and services, and exits custody within the statutory time limits. Continued implementation of this program will also serve to further reduce backlogged cases and prevent future backlogs from occurring.

Formula Funded Programs: Foster Care and Subsidized Adoption & Guardianship

Foster Care Base Rate

The Division projects that the overall foster care caseload will remain steady for the next two years. The Division estimates 13,697 FTE's in FY2002 and FY2003, a daily average of 1,141 children in foster care.

The following table shows the growth in the foster care caseload from FY1997 through FY2003. The foster care caseload increased by 16.8% in FY1998 and by 16.4% in FY1999. In FY2000 the caseload grew by only 5.8% to 14,598 total FTE's for a daily average of 1,216 children and decreased 6.2% in FY2001. The reduction in the foster care caseload growth rate is, in part, a reflection of the success of statewide permanency planning initiatives Project SUCCEED and the Adoption Placement Program (formerly the Balloon Project) to move children out of foster care and into permanent homes. In FY2000 Project SUCCEED and the Balloon Project provided funding for DFYS and partner legal agencies including the Department of Law, the Public Defender Agency and the Office of Public Advocacy to focus on moving children on the "transition list" that have been in custody the longest from the foster care system and into permanent homes. (See discussion on the Adoption Placement Program above).



Summary of the Foster Care Base Rate Caseload Growth:

Fiscal Year	Number of FTE's	Percent of Change
FY1997	10,153	
FY1998	11,854	16.8%
FY1999	13,793	16.4%
FY2000	14,598	5.8%
FY2001	13,697	-6.2%
FY2002 Projected	13,697	0.0%
FY2003 Projected	13,697	0.0%

Foster Care Daily Rate Increase of 13.5%

The Division requests a $1,258.5 increment to cover the cost of an increase in the daily foster care rate of the Foster Care Base Rate program. The current Foster Care Base Rate set in 1998 is based on the federal poverty guidelines of 1993 and does not reflect overall cost of living increase of 23.45% that has occurred since that time. The Department proposes to increase the daily base rate to the 1997 poverty guidelines, an increase of 13.5% over the 1993 level. Even with this modest increase foster care providers will receive 90.1% of the 2001 federal poverty guidelines, 9.9% less than the current poverty guidelines. The daily rate increase will raise the base rate from the FY2000 and FY2001 average of $22.34 per day to $25.36 per day, an increase of $3.02 per day.

Average Daily Cost of Care

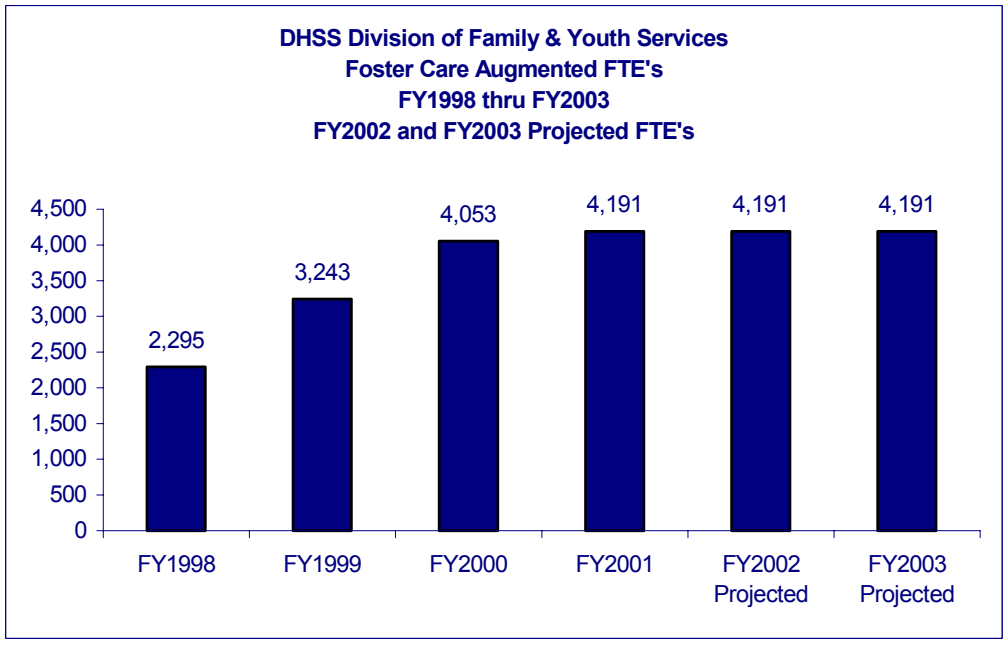
The projected average daily cost per child in foster care is approximately $28.74 ($22.34 for Foster Care Base Rate and $6.40 for Foster Care Special Needs). In addition, approximately 30.6% of the foster care caseload receive a rate augmentation, at an average rate of $20.15 per day, due to increased special needs and/or difficulty of care.

Foster Care Augmented Caseload Growth

The Augmented Foster Care program reimburses foster care providers for extraordinary costs and for higher levels of supervision not otherwise covered by the Foster Care Base Rate program. When children enter foster care with a higher level of disturbance, foster parents are required to access a higher level of services to meet their needs (i.e., physical, and/or psychological therapy, supervised visits with family members, individual education plans, tutoring).

As shown in the following table, in FY1998 approximately 19.4% of the children in foster care received a rate augmentation. In FY1999 23.5% of children received augmented rates, in FY2000 27.8% received augmented rates and in FY2001 30.6% of children in foster care received an augmentation to the foster care base rate. The Department projects the FY2002 and FY2003 augmented rate to remain constant at the current level.

Fiscal Year	Number of FTE's	Number Augmented	Percent Augmented
FY1998	11,854	2,295	19.4%
FY1999	13,793	3,243	23.5%
FY2000	14,598	4,053	27.8%
FY2001	13,697	4,191	30.6%
FY2002 Projected	13,697	4,191	30.6%
FY2003 Projected	13,697	4,191	30.6%



Although the Division anticipates that the percentage of augmented cases will remain constant at 30.6% in FY2002 and FY2003, an increment of $63.0 has been submitted to cover the cost of caseload underfunding for the Foster Care Augmented program.

DFYS Has Improved Augmentation and Special Needs Standardized Guidelines In FY2000 the Division redesigned and implemented guidelines to standardized rates and improve equity between foster care providers. In FY2001 the Department continued to use this method to determine the level of care and special needs of children. Services were provided to meet the assessed needs of children in custody or under Division supervision on an as-needed basis that is consistent with the child's case plan. General categories accessed include:

- Difficulty of care maintenance payments (Justified with Difficulty-of-Care Guidelines and Case Plan)
- Teen parent/baby
- Sibling groups (3 or more children)
- Medically fragile children

Decisions on whether to pay Augmented Foster Care rates are made on a case-by-case basis in accordance with Division policy and State and Federal foster care regulations. Augmented rates must be approved in advance by regional management based on documented assessed needs. Each case must be reassessed at least every six months to determine whether continuation of augmented foster care rates are necessary and in the best interest of the child.

In FY2001 the Division continued to use the Foster Care Placement Level Checklist which standardizes how augmented foster care rates are assessed and defines the specific problem areas and the degree of severity. The three assessment levels include Basic, Specialized, and Structured care. The checklist guidelines also include three separate age categories, 0 to 5 years, 6 to 11 years, and 12 to 18 years. The Level Checklist provides standardized criteria for assessing the difficulty of care for a child and should increase parity of payments between providers.

The following table provides examples of the types of conditions that may result in a child receiving augmented foster care. (Data excerpted from the Foster Care Level Checklist for children ages 0 to 5 years old).

PROBLEM AREAS	BASIC RATE	SPECIALIZED RATE	STRUCTURED RATE
☐ Fetal Alcohol Syndrome/ Drug Affected		☐ Fetal Drug Addiction/ Affected ☐ Fetal Alcohol Syndrome	
☐ Physical Disabilities		☐ Moderate Disability	☐ Severe Disability
☐ Serious Medical Problems	☐ Monitor Weekly or Less	☐ Monitor Daily/Hourly ☐ Chronic Shaken Baby Syndrome	☐ Life Threatening
☐ Mental Disabilities		☐ Learning Disability ☐ Mild Retardation	☐ Moderate Retardation ☐ Severe Retardation

Foster Care Special Needs
The Foster Care Special Needs program is designed to reimburse foster care providers for "one-time" or "irregular" expenses that are not covered by the Foster Care Base Rate or are not being paid by the Foster Care Augmented program. As discussed in Foster Care Augmented section above, in FY2001 the Division redesigned and implemented new standardized guidelines to standardize rates and improve equity between foster care providers. Some types of expenditures have resource equity criteria assigned, and all expenditures must be based on documented assessed need.

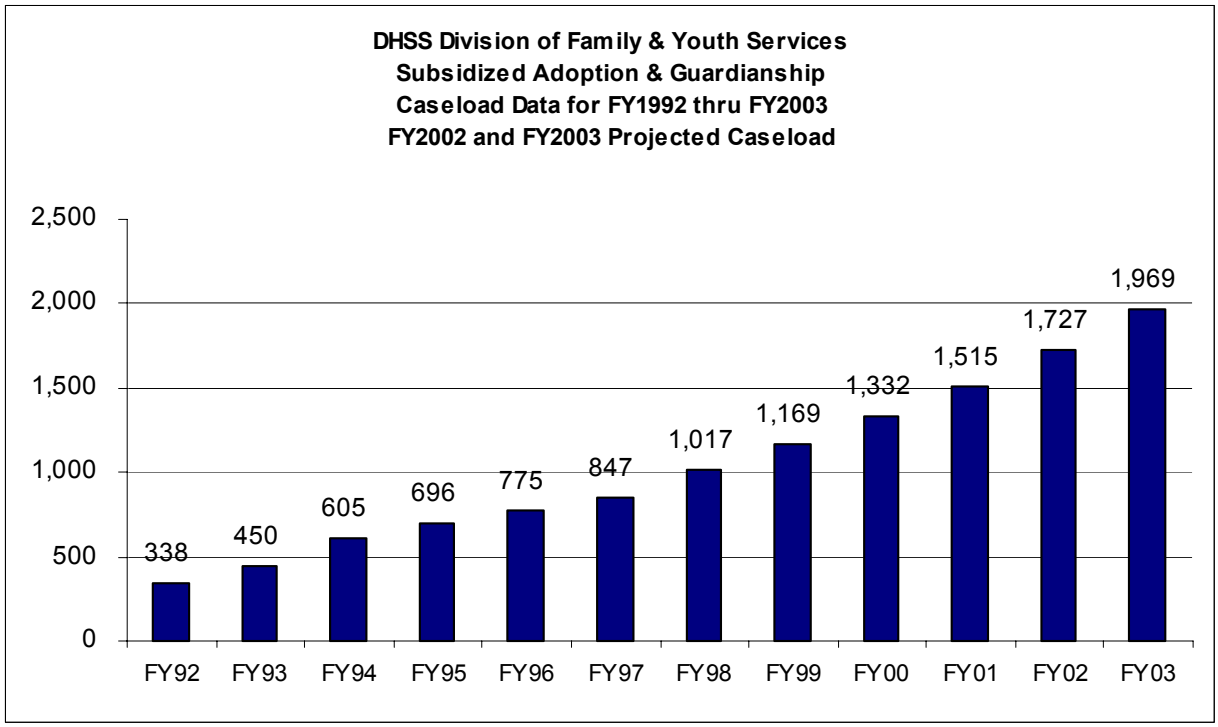
Examples of allowable expenditures include extraordinary clothing for medically fragile children and for children experiencing a growth spurt; food for special diets for children that cannot eat a regular diet (must be recommended by a doctor); extraordinary laundry; medical, dental, diagnostic, assessment, treatment services, and medical equipment for foster children that are not covered under Medicaid or other third-party coverage; special equipment, furniture, and services such as special cribs, beds, mattresses for persons with disabilities; and travel for children in foster care to visit with their families;

Foster Care Special Needs: Caseload under funding
The Department requests an increment of $595.3 to cover the projected cost of under-funded caseload growth. The Department anticipates the Foster Care Base Rate and Foster Care Special Need caseloads will remain steady at 13,697 FTE's (an average of 1,141 children) during FY2002 and FY2003.

Foster Care Special Needs: Child Care to Unlicensed Relatives Providing Foster Care
The Division requests a FY2003 budget increment of $500.0 Interagency Receipts to provide child care to unlicensed relatives who are foster care providers to children in state custody. Children who are not free from abuse and neglect and can no longer remain in their home are taken into state custody and placed in foster homes. Frequently these emergency placements are with relatives who are not licensed foster care providers. Although the Division may reimburse licensed foster homes for child care, unlicensed relatives who incur child care costs remain uncompensated for the cost of child care. This increment will enable the Division to provide reimbursement to these unlicensed relatives who provide child care to children in state custody. The Division anticipates providing this service for 105 children ranging from 0-5 years of age in FY2003 and 115 children ranging from 6-11 years of age.

Subsidized Adoption & Guardianship

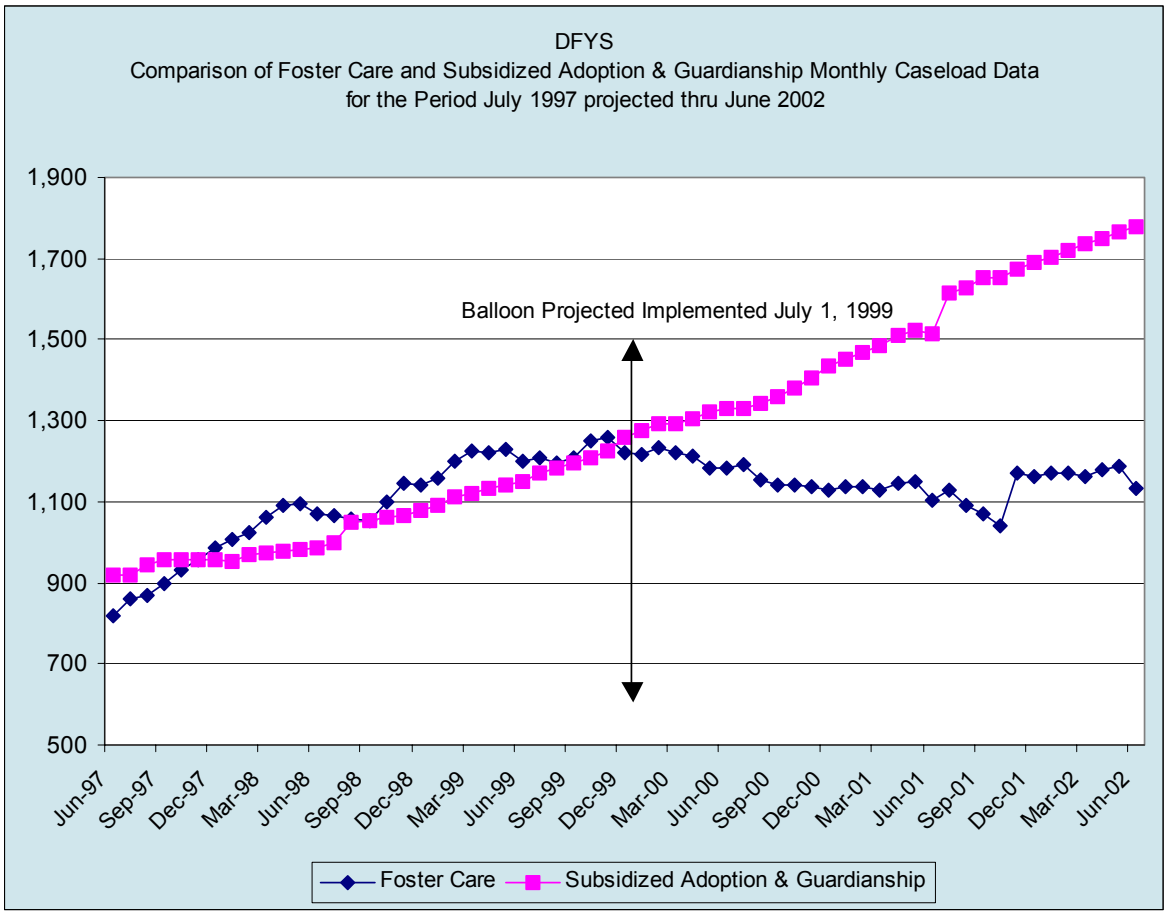
Caseload Growth: The Department requests an FY2003 budget increment of $3,641.9 to cover the cost of a projected 14% growth in the Subsidized Adoption & Guardianship Program. This increment is necessary to ensure continuity of subsidy payments and continued success of the subsidy program. The following table shows the number of children in the Subsidized Adoption & Guardianship program from FY1992 to FY2003 (FY2002 and FY2003 are projected based on 14% annual growth). At the close of FY2001 there were 1,515 children in the Subsidized Adoption & Guardianship program. The Department anticipates the number of children in the program to increase by 14% to 1,727 at the end of FY2002 with an additional 14% growth to 1,969 in FY2003.



Summary of the Subsidized Adoption & Guardianship Caseload Growth

Fiscal Year	Number of Children	Percent of Change
FY1992	338	
FY1993	450	33.1%
FY1994	605	34.4%
FY1995	696	15.0%
FY1996	775	11.4%
FY1997	847	9.3%
FY1998	1,017	20.1%
FY1999	1,169	14.9%
FY2000	1,332	13.9%
FY2001	1,515	14.0%
FY2002 Projected	1,727	14.0%
FY2003 Projected	1,969	14.0%

The following chart provides a comparison of the Foster Care and the Subsidized Adoption & Guardianship program monthly caseload data for the period July 1997 projected through June 2002. As discussed above, the chart illustrates the steady growth of the subsidy program and the leveling-off of the foster care caseload.



State and Federal law, including Alaska's HB 375 (Chapter 99, SLA 98) and the Federal Adoption and Safe Families Act of 1998, mandate the Department to increase the emphasis on permanency planning and to move quickly to find permanent homes for children in State custody. From FY1992 to FY2001 the number of children removed from the Foster Care system and placed in a permanent adoptive or guardian home increased from 338 to 1,515. This represents a 348% increase during this nine-year period.

Several factors have contributed to the success and growth of the Subsidized Adoption & Guardianship program. New Federal and State policies calling for increased emphasis on permanency planning have been implemented including the Adoption Placement Program (formerly the Balloon Project) to speed up permanency decisions. The Adoption Placement Program provides funds to DFYS, the Attorney General's office, the Public Defender Agency, and the Office of Public Advocacy to increase the State's ability to comply with State and Federal permanency planning mandates and to focus on the legal proceedings needed for children who have been in custody the longest period of time. In FY2001 the Balloon Project continued to fund 14 long-term non-perm

DFYS social workers positions that worked exclusively on the "Transition List" of children that have been in custody the longest.

The Subsidized Adoption & Guardianship program provides the State with a cost effective alternative to foster care. State law stipulates that adoption and guardianship subsidy payments may not exceed what would have been paid had the child been in foster care. The FY2002 projected average daily cost per child for the Subsidized Adoption & Guardianship program is $22.77 compared to an average daily cost of $28.74 for children in foster care (includes the Foster Care Base Rate and Foster Care Special Needs programs). In addition, in FY2002 the Division projects approximately 30.6% of the children in foster care will have special needs and receive a rate augmentation, which averages $20.15 per day. There are also indirect cost savings for Subsidized Adoption & Guardianship cases because these children are typically not carried as part of the DFYS social worker caseloads.

Average Daily Cost of Care for Children in Foster Care & the Subsidized Adoption & Guardianship Program

FY2002 Foster Care Average Daily Rates:		
Foster Care Base Rate	$22.34	
Foster Care Special Needs	$6.40	
Foster Care Augmented:	$20.15	
Foster Care Base Rate & Special Needs:	$28.74	
Foster Care with Augmentation:	$42.49	(approximately 30.6% will receive augmentation)
Subsidized Adoption & Guardianship:		
(Based on $683.10 Avg. Monthly Subsidy)	$22.77	

Residential Child Care – Mental Health Stabilization Beds

Mental health stabilization beds provide a short-term residential option that serves as a step down from more restrictive care or as an interim setting for children with emotional disturbances that are difficult to place. This placement alternative will expand options and allow families and providers a safe and appropriate community placement. This $650.0 project will be funded through Interagency Receipts, General Fund, and MHTAAR funds.

This funding will provide five short-term (defined as 2 to 4 months) mental health stabilization beds for DFYS and DJJ youth waiting for permanent placement. This project is a collaborative effort between DFYS, DJJ and DMHDD. DFYS will be the lead division, will provide the funds, and monitor the project with input from DJJ and DMHDD. The mental health stabilization beds will be part of the continuum of residential childcare services provided by DFYS and will be incorporated into residential diagnostic treatment facilities. The Department projects that with the length-of-stay limitations, this project will potentially serve up to 20 children per year.

Residential Child Care

The Division requests a $6,087.8 Interagency Receipt budget increment for Medicaid financing of Behavioral Rehabilitation Services (BRS). The Division will provide Behavioral Rehabilitation Services for Medicaid eligible children in state custody who reside in residential care facilities. DFYS will provide 24-hour care for children in the custody of the Department who are not able to remain in their own home or who need more structure and treatment than can be provided in foster

care. Through its Residential Child Care component, the Division will issue competitive grants to non-profit agencies for high quality, time limited residential treatment services and will require providers to provide Behavioral Rehabilitation Services to each child served within a Level 2, 3, or 4 Residential Care Center.

Family Preservation – Early Intervention for Family Support
The Department requests an $975.0 increment to expand the Early Intervention for Family Support pilot project that originated in Mat-Su to the Fairbanks, Bethel and Kenai areas. This program provides grant funds to a non-profit community agency to perform intervention and follow-up work for cases that the Division has assessed as being low risk. This program enables the Division to focus more social workers on investigating higher priority reports of harm. This program also allows for early intervention that minimizes the risk to children and often negates the need for out-of-home placements or further agency intervention.

Family Preservation – Child Advocacy Centers
The Department requests a $1,000.0 increment of federal receipt authority to establish Child Advocacy Centers. These centers are a designated neutral facility with designated staff from either a non-profit organization or a government agency. Child Advocacy Centers provide on-site medical evaluation and mental health services or referral to these services, training for center staff, case tracking, multidisciplinary case review and joint investigations designed to reduce the number of victim interviews and improve case coordination. Staff from local law enforcement agencies, child protection and prosecution agencies as well as local advocates, mental health centers or medical facilities will work together on child maltreatment cases, identify what confidential information they will share, and determine what resources they will commit to their effort.

Family Preservation – Family Visitation Centers
The Department requests $750.0 to implement Family Visitation Centers in Anchorage, Fairbanks, Mat-Su, Kenai, Juneau, and Bethel. Supervised visitation is needed when there is any situation that may place a child at risk. The purpose of supervised visitation programs is to provide a safe, friendly environment that maintains and fosters the relationship of a child with his/her parents. The positive impacts of Family Visitation Centers include shortened duration of the family's involvement in the system, frequent reunification and the opportunity for the child to maintain a secure attachment with his/her parents. Additional benefits are an increased likelihood of positive development on the child, providing courts with more information regarding the parental relationship and the child, and increased frequency of visits between the child and the parents.

Family and Youth Services - BRU Consolidation
Consolidation of the DFYS Family Services BRUs: Under the current budget structure, separate BRUs are maintained for the Front Line Social Workers, Family & Youth Services Management, and Staff Training. The Department has reviewed this current budget structure and has determined that organizationally it would be more cohesive to combine these three BRUs into a single Family & Youth Services BRU. The new BRU will be composed of four separate components including Front Line Social Workers, Family Services Management, Adoption Placement Program, and Family & Youth Services Staff Training. One function of the Family & Youth Services Management component is to provide programmatic and administrative support to the front line social workers. Similarly, the primary purpose of the Family & Youth Services Staff Training component is to provide requisite core training to new workers and on-going training to existing workers.

Consolidation of these three BRUs into a single Family & Youth Services BRU will increase organizational efficiency; reduce, simplify and enhance the Department's ability to process federal revenue and should otherwise reduce the administrative burden.

Family and Youth Services Management – Program Management
The Department requests a $498.6 interagency receipt increment to account for the costs and revenue associated with management of federal programs, formula funded programs and the residential care program. Program Management involves the Independent Living program, a new federal program to assist the youth aging out of foster care. This program targets the youth aging out of foster care and prepares them to find jobs, manage their finances, and other tasks necessary to prepare them to be independent. Additional programs Family and Youth Services Management administer include the Office of Juvenile Justice and Delinquency Prevention funding to establish Child Advocacy Centers in Alaska, and the growth in the Subsidized Adoption and Guardianship program that requires additional staff resources to process monthly subsidy payments. The billing and accounting requirements of the Residential Care program have also resulted in additional revenue and expenditures. The logistical and clerical support of the development of the Division's information system, ORCA, requires the establishment of a clerical position. The proposed increase authority will budget the revenue and expenditures for continued services to these programs.

Front Line Social Workers - Transcription Services
The Department requests a $450.0 General Fund increment to provide statewide implementation of case note transcription services for DFYS social workers. Transcription Services is a telephone dictation service that allows social workers to maintain current, accurate case files without increasing the need for internal clerical support. Social workers call a toll free number and dictate their case documentation at any time from a touch tone telephone. Dictation is digitally recorded, transcribed, and electronically transmitted to the agency's office (to the worker's computer) in less than two business days. This brings case documentation that is backlogged in some offices up to real time. This will increase safety to children since this information creates a historical record needed to assess continued risk.

DFYS initiated a Pilot Transcription Project in January 2000. Preliminary review of this project shows that workers using transcription services spend on average 7.5 hours, or one work day per week, less completing paperwork. These social workers have been able to spend more time with children, families and service providers, including foster parents. The increase in client time will result in more contact with children in foster care, better services to families, more support for foster parents, and better communication with other service providers.

Front Line Social Workers – Mental Health Clinicians in Licensing Units
At a cost of $172.0, the Division plans to place Mental Health Clinicians in the Fairbanks and Mat-Su licensing units to help prepare foster parents for the special needs of the children placed in their home. These Mental Health Clinicians will be able to assist foster parents by reviewing documentation on the child and providing child-specific information to the foster parent on how to deal with the specific needs of the child. The Mental Health Clinician will help the foster parent to identify behavior modification techniques that work with the child and that are comfortable for the foster parent. They will also provide information to the foster parent on what to expect from the child, given the behavioral and mental health issues identified. They may conduct family meetings prior to or after the placement of the foster child to ease the transition. This preparation and support will strengthen the placement and reduce the potential that the child will have to be moved.

The Division expects to see a reduction in the number of placements foster child experience and an increase in retaining foster parents through increased support of foster placements and improved matching of needs of children with skills of foster parents.

Front Line Social Workers – Department of Education and Early Development Child Care Licensing Efforts

The Department requests an increment of $163.3 interagency receipts to cover the costs of implementing the proposed changes in the child care licensing regulations which pertain to background checks on licensed child care providers.

Front Line Social Workers - Anchorage and Mat-Su Leases

The Division has submitted an increment of $550.0 for increased lease costs for the Anchorage and Mat-Su field offices. Without adequate space crowded conditions require many of the professional staff to share an office. Currently, approximately 60% of the Anchorage staff are required to share offices. In offices that are shared, clients cannot meet one-on-one with their social worker. This affects confidentiality and rapport building between the client and the social worker, as clients are more likely to communicate openly and effectively when they have privacy. Increased caseloads have also resulted in the need for more and adequate interview and family visitation rooms for children to visit with their biological parents and foster parents. Without adequate office space family interaction is sometimes required to be held in lobby areas, employee break rooms, employees' offices, and during the summer months, on the front steps of the building. Parents and children deserve a therapeutic and calming space to visit during this stressful time.

The Mat-Su field office currently experiences many of the same conditions that the Anchorage office does. For instance, when DFYS is involved in a family's life, it can be demoralizing to that family. Lack of adequate space can add to the unsettling nature of the client/worker meetings and frequently prevent social workers from meeting with the family members in a confidential, private setting.

Front Line Social Workers - Relative Navigators

The Department proposes to implement the Relative Navigators pilot project in the Anchorage area. This project, at a cost of $60.0, provides assistance to regional staff and workers in locating adult relatives of children who are in state custody, and will work with these relatives in becoming foster and adoptive families. The Relative Navigator will be dedicated solely to identifying possible relatives, locating and contacting them, and wherever appropriate, helping to place the children in relatives' homes.

When it is no longer safe for children who suffer from abuse or neglect to remain at home, the State must provide for the care of that child by placing the child in a foster home or in the care of an agency or institution. Very often, the home of a relative is the most appropriate and nurturing environment for the child. When a child is placed with a family member, he or she can usually maintain contact with their family members and with their cultural heritage. Statistics show that placements with relatives are the most successful, whereby the children do not have to be moved again and again. In cases where the child cannot be returned to the birth parents, family members more often agree to adopt or assume guardianship than do foster parents. Children who are placed in relative care will find a more stable, long-term placement, thereby decreasing the average number of placements per child in Alaska's custody. Additionally, children will reach relative homes sooner thereby reducing the need for foster care.

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Division of Juvenile Justice

Mission

The mission of the Division of Juvenile Justice is to hold juvenile offenders accountable for their behavior, promote the safety and restoration of victims and communities, and assist offenders and their families in developing skills to prevent crime.

Introduction

The Division of Juvenile Justice provides juvenile justice services. The Division responds to the needs of juvenile offenders in a manner that is consistent with protection of the public; prevention of repeated criminal behavior; restoration of the community and victims; and the development of the juvenile into a productive citizen. Services are provided in the least restrictive and most effective setting for the youthful offender.

Probation Services
Juvenile probation officers provide preventative and rehabilitative services by conducting intake investigations of youth who are alleged to have committed delinquent acts; completing detention screening, implementing diversion plans; initiating formal court action against juvenile offenders and providing formal community probation supervision services for adjudicated youth.

Juvenile Detention and Treatment Facilities
Youth facilities in Alaska perform two primary functions. Detention Units are designed as short-term secure units for youth who are awaiting court hearings. Treatment Units are designed for youth who have been ordered by the courts into long-term secure treatment.

FY2001 Delinquency Referral Summaries *

Charge Type	Number of Reports	Percent of Total
Against Persons	1,277	18.2%
Property	3,761	53.7%
Public Order	361	5.2%
Drug/Alcohol	597	8.5%
Weapon	104	1.5%
Miscellaneous offenses	908	13.0%
Total	7,008	100.0%

Charge Class	Number of Reports	Percent of Total
Felony	2,090	30%
Misdemeanor	4,007	57%
Violation/Other	407	6%
Probation Violation	504	7%
Total	7,008	100%

Intake Determination	Number of Reports	Percent of Total
Adjusted	2,779	40%
Dismissals	744	11%
Informal Probation	417	6%
Petitioned	1,985	28%
Community Justice Panel	771	11%
Screen & Refer	202	3%
In Process	110	2%
Total	7,008	100%

Race	Number of Reports	Percent of Total
Alaska Native/Native American	2,424	35%
African American	435	6%
Caucasian	3,451	49%
Hispanic	148	2%
Asian/Pacific Islander	337	5%
Other/Unknown	213	3%
Total	7,008	100%

Age at Referral	Number of Reports	Percent of Total
Less than 10	114	2%
10-12	684	10%
13-14	1,782	25%
15-17	4,297	61%
18 +	131	2%
Total	7,008	100%

Gender	Number of Reports	Percent of Total
Male	5256	75%
Female	1752	25%
Total	7,008	100%

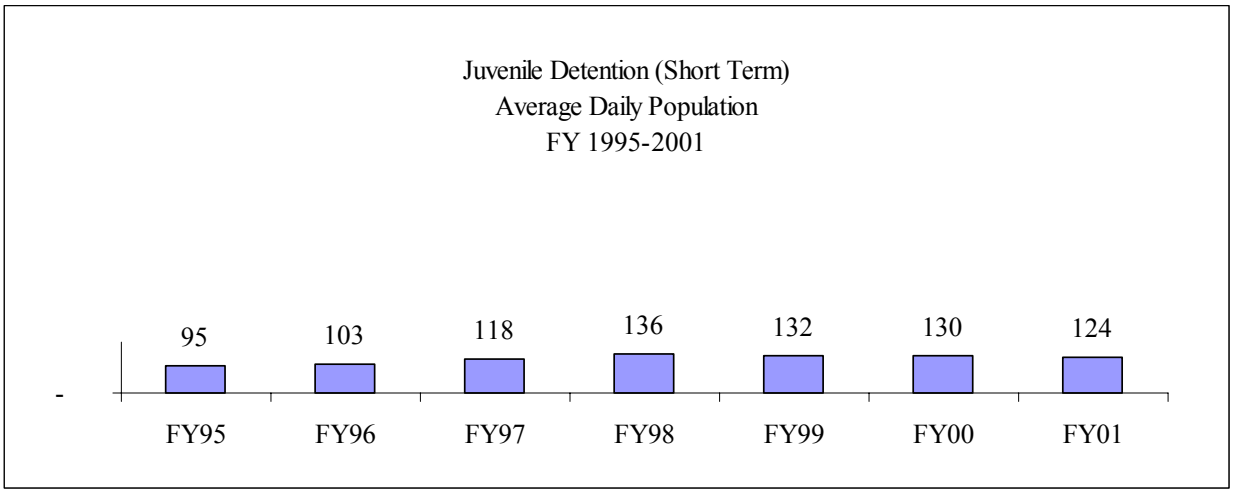
Youth Facility Current and Planned Capacity

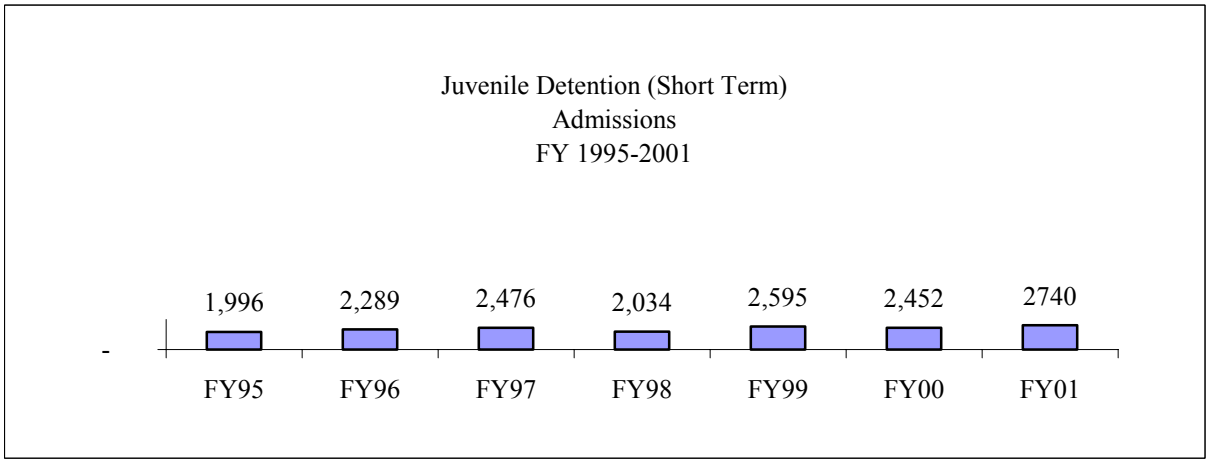
	Existing Capacity	New Beds	Total Beds
McLaughlin Youth Center	200		200
Fairbanks Youth Facility	40		40
Johnson Youth Center	30		30
Bethel Youth Facility	19		19
Nome Youth Facility	6		6
Mat-Su Youth Facility	15		15
Ketchikan Youth Facility	10		10
Kenai*	0	10	10
Total	320	10	330

*Planning and Design completed.

Facility Data

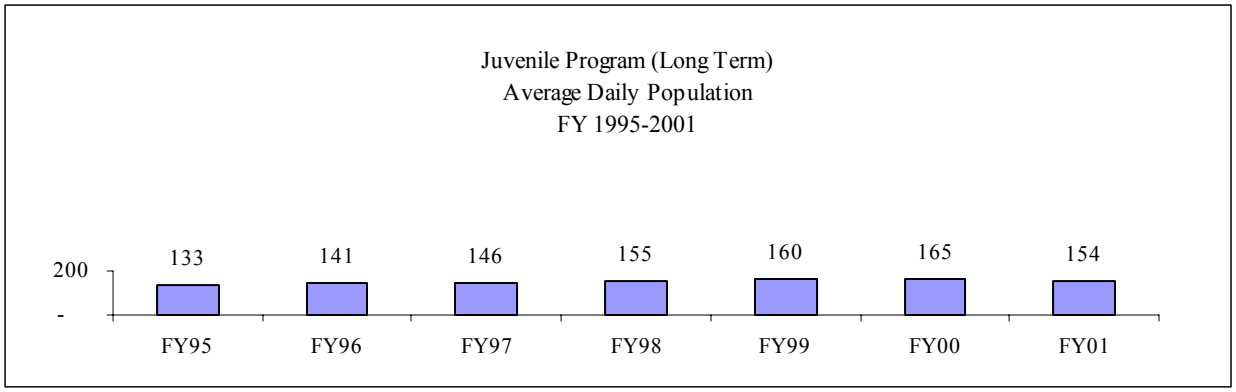
Detention Units – Detention and Treatment Units
Below are charts showing juvenile detention admissions and average daily population for FY 1995 to FY 2001. Detention Units are designed as short-term secure units for youth who are awaiting court hearings.

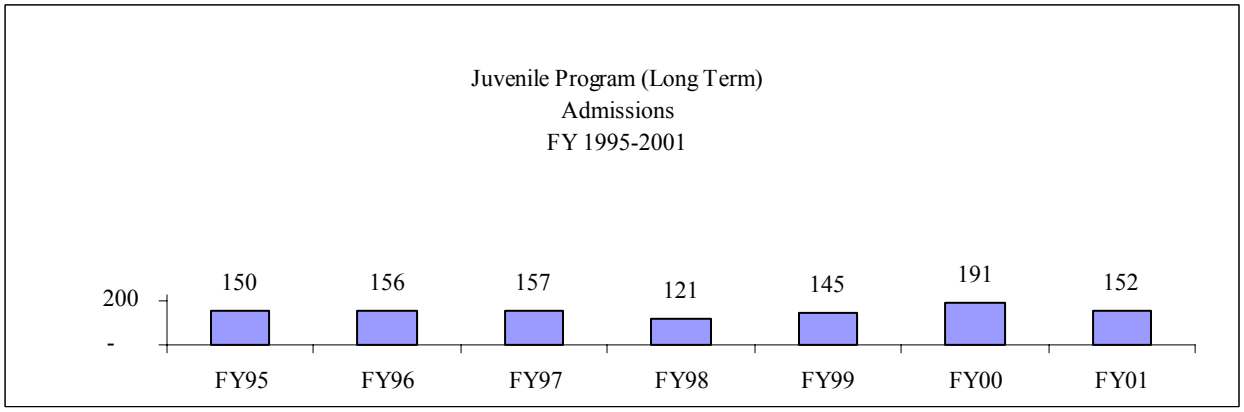




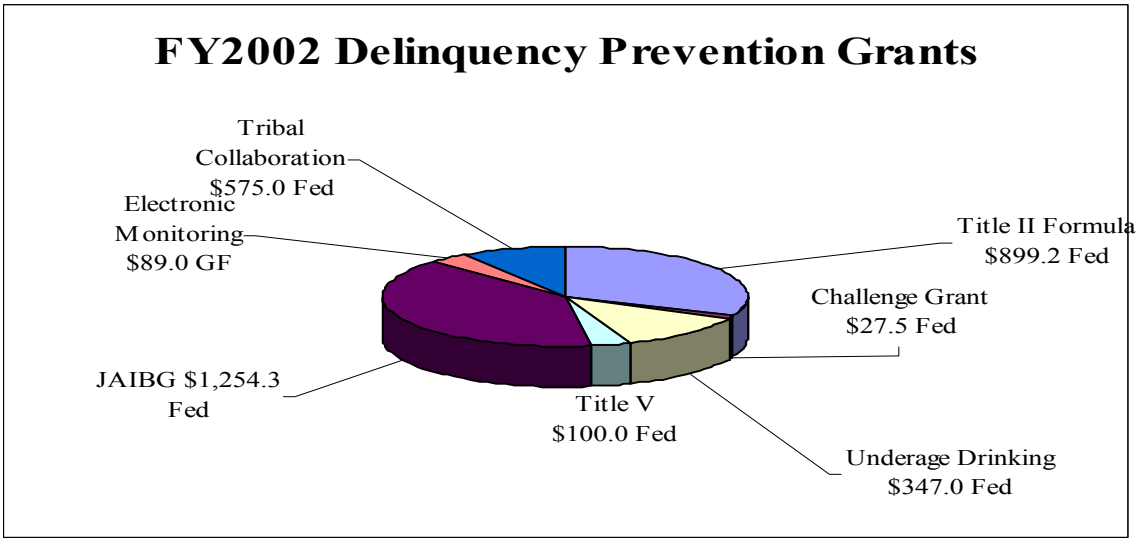
Treatment Units

Below are charts showing juvenile program admissions and average daily population for FY 1995 to FY 2001. Treatment Units are designed for youth who have been ordered by the courts into long-term secure treatment.





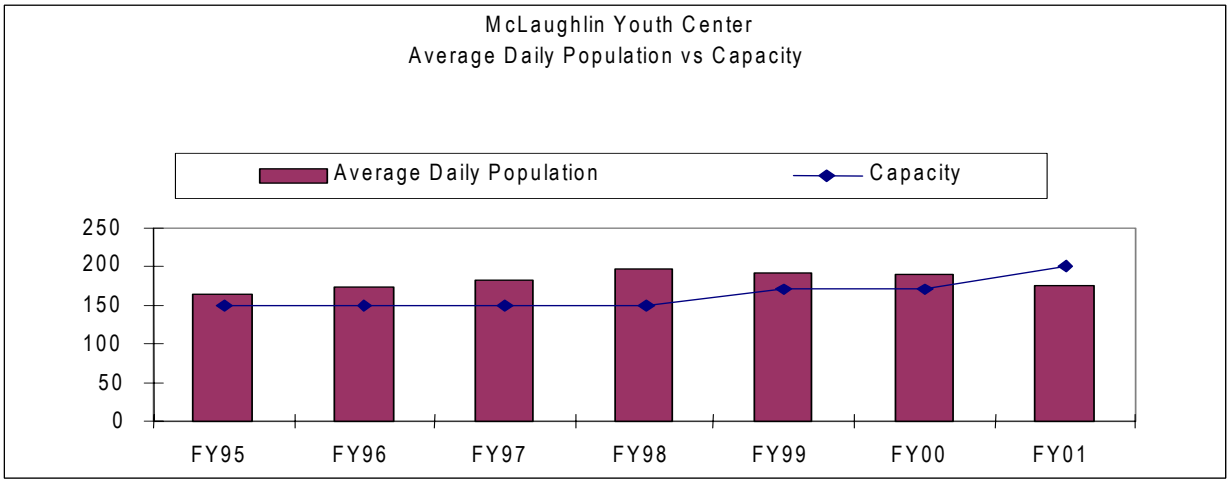
The Alaska Juvenile Justice Advisory Committee (AJJAC) serves as the Congressionally mandated state advisory group to the Division in its use of federal funds and juvenile justice programming. The following chart provides a visual breakdown of the FY2002 grant programs funded in the Delinquency Prevention Component: $3,203.0 Federal and $89.0 General Funds.



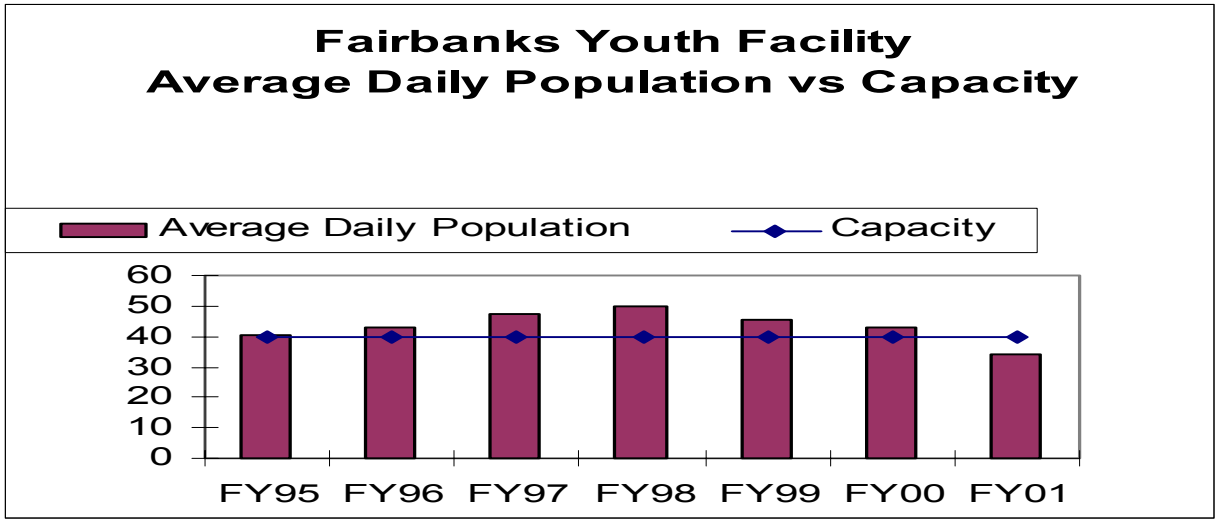
Delinquent Minors (Alaska Statute 47.12)
The Division, through its Juvenile Probation Officers, determines whether juvenile cases are handled informally through community diversion programs or for more serious offenses, through the court system. This statute also allows for the temporary detention of minors and long-term institutional care.

Juvenile Programs and Institutions (Alaska Statute 47.14)
The Division operates youth facilities in Anchorage, Mat-Su, Fairbanks, Juneau, Bethel and Nome. The Mat-Su Youth Facility in Palmer opened October 9, 2000, and the Ketchikan Regional Youth Facility is scheduled to open Winter 2001. Probation offices are located in these same communities as well as Sitka, Petersburg, Kenai, Kodiak, Dillingham, Homer, Valdez, Barrow, and Kotzebue.

McLaughlin Youth Center (MYC)
MYC, because of its size and history as the State's first facility, has developed a range of program options that do not exist in most of the smaller facilities. In addition to providing both Detention and long term treatment, MYC provides sex offender treatment, a separated girls detention and treatment unit and a closed treatment unit (CTU) for juveniles whose behavior or history require a high level of security and treatment. The Detention Units serve the Third Judicial District, which includes the Municipality of Anchorage, Matanuska-Susitna Borough, Kenai Peninsula, Cordova, Valdez, Kodiak, Dillingham and Aleutian/Pribilof Islands. The Training School (four Cottage Programs, Classification Unit and Closed Treatment Unit) provides long-term residential services for institutionalized delinquent adolescents, primarily from the Third Judicial District.

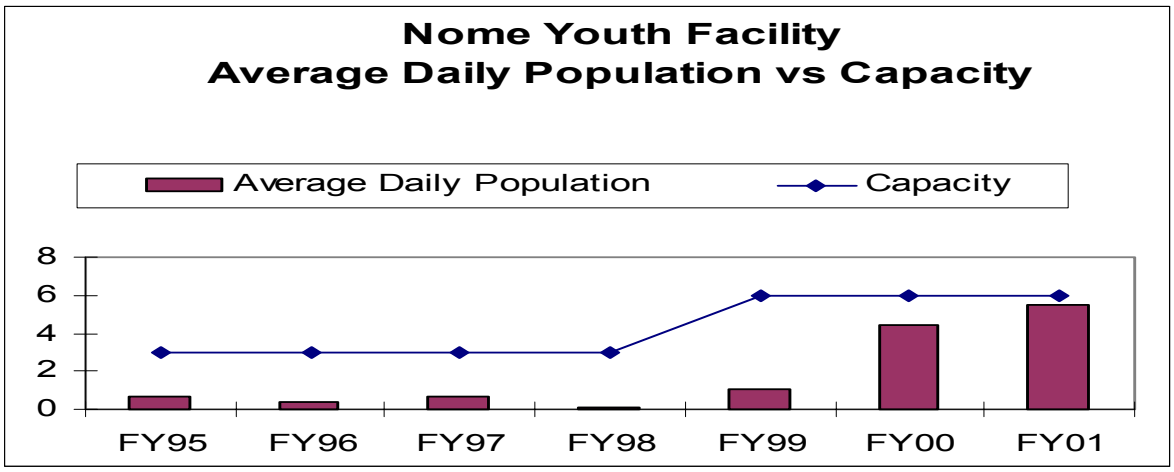


Fairbanks Youth Facility (FYF)
FYF consists of a twenty bed Detention Unit and a twenty bed Treatment Unit. The Detention Unit houses and offers services to alleged and adjudicated offenders who are either involved in the court process or awaiting other placement. The Treatment Unit houses and makes rehabilitative services available to adjudicated offenders who have been institutionalized by the Court. The Fairbanks Youth Facility is the second largest of Alaska's juvenile correctional facilities and the Northern Region is the largest geographical area served by the Division in the State. FYF is now one of the state's oldest facilities that has not had the benefit of significant rehabilitation or modification of its physical plant. There are crucial additions and renovations necessary in the near future for this facility to perform its mission in a safe and appropriately programmed way.



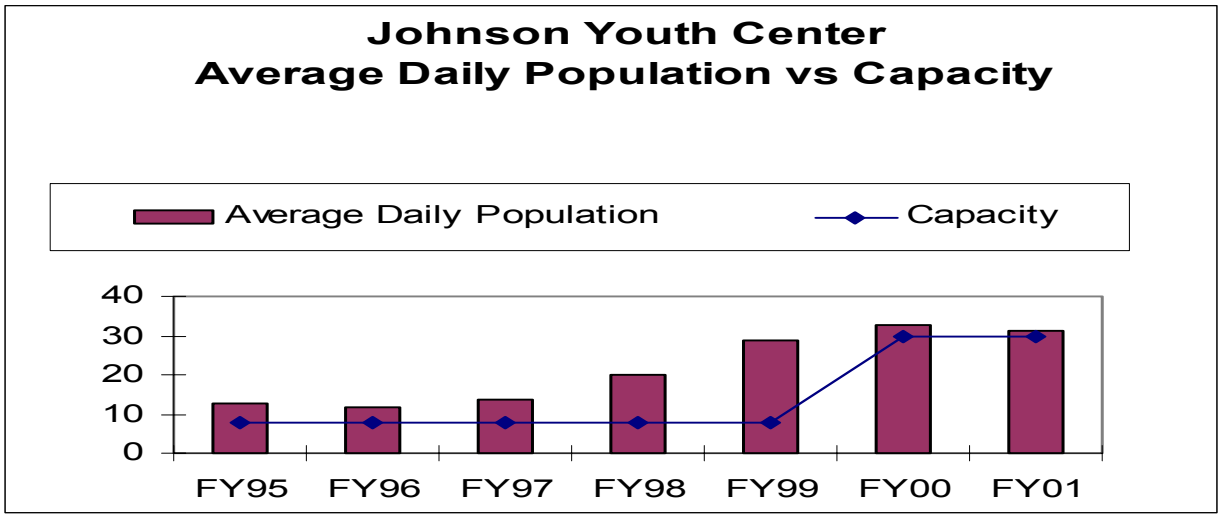
Nome Youth Facility

NYF operates as a short-term detention facility for juveniles of the Nome and Kotzebue region. Treatment services have steadily grown for the residents with a new program focusing on accountability. The facility is considered minimum security and holds up to six residents. The resident population is primarily male and nearly all Alaska Native. The residents are commonly detained for property crimes but there has been an increase in the number of residents charged with assault being held at the facility. Many of the youth have a history of substance abuse. Nome is an aging facility with significant capital needs that must be addressed if it is to continue to effectively serve the Northwest area of the state. Significant space issues prevent implementation of programs for juveniles both in the facility and on probation. The low staffing level remains one of the most significant safety/security concerns. This has been exacerbated as the resident count has increased and now commonly exceeds capacity. For a 24 hour/7day a week facility there are simply not enough staff. Recruiting for these positions has been very difficult. This has necessitated the extensive use of less experienced non-permanent/on-call staff. There has also been a very high turnover of these on-call staff. This situation not only creates obvious safety issues, but also impairs the staff's ability to work with the resident population, having to spend all their time on safety and security issues. As staff leave accumulates or the need for staff training is identified, shift coverage problems become even more problematic.



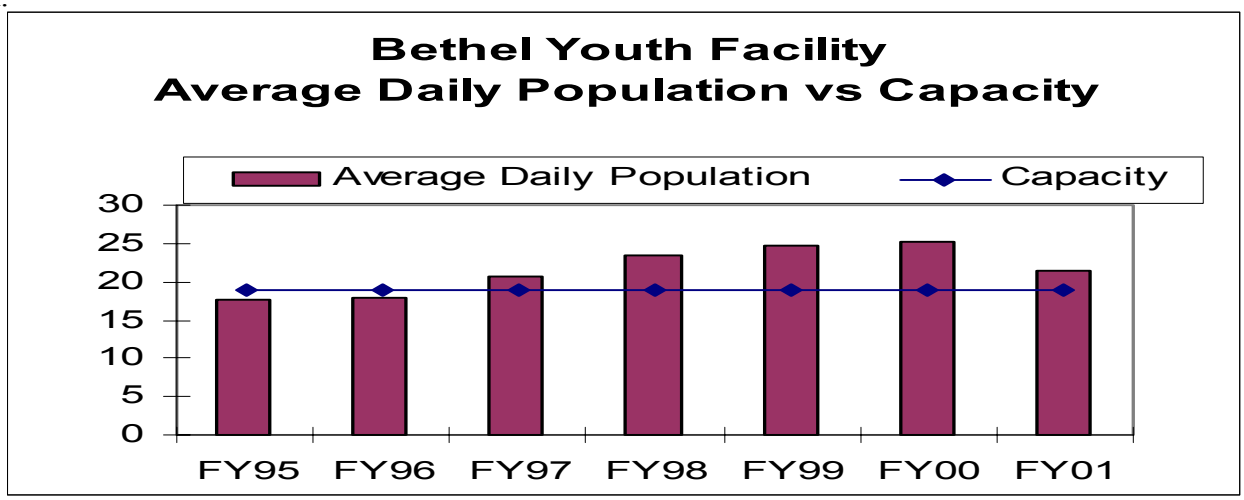
Johnson Youth Center

JYC is a 30-bed facility that provides short-term, pre-trial detention, control and intervention for juveniles whom the Superior court has ordered confined due to the danger they present to the public and/or themselves. The Johnson Youth Center Detention Unit provides an array of basic and specialized delinquency intervention services. JYC has one of the newest treatment units in the state. The juveniles that it serves and all of Southeast Alaska have benefited from this addition to the facility. Many juveniles who previously had to leave the area for treatment can now be treated in or near their home community.



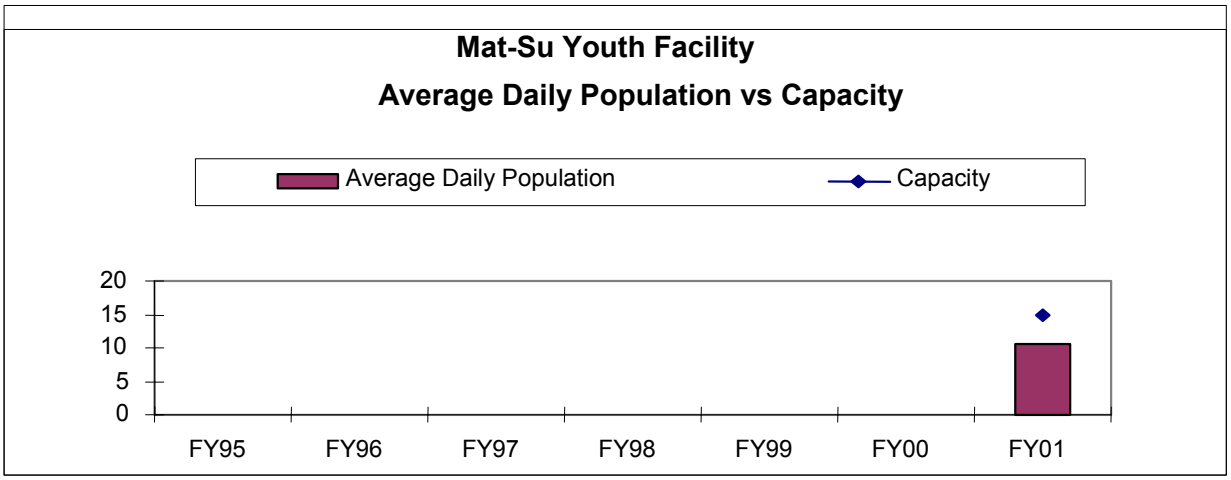
Bethel Youth Facility

BYF consists of an eight bed Detention Unit and an eleven bed Treatment Unit. The Detention Unit houses and offers services to alleged and adjudicated offenders who are either involved in the court process or awaiting other placement. The Treatment Unit houses and makes rehabilitative services available to adjudicated offenders who have been institutionalized by the Court. Both Units are co-ed, and at this point in time our Treatment Unit is the only co-ed institutional treatment program in the Northern Region. The facility's population is largely Alaska Native, particularly Yup'ik Eskimo, and comes to the facility from a wide geographical area including Southcentral communities as well as Barrow, Nome, Kotzebue, Fairbanks and the Yukon-Kuskokwim Delta. Residents of the Bethel Youth Facility continue to represent a broad range of offenses, but in recent years we have seen a disturbing number of violent and high profile offenses. In addition to the violent offenders housed in the facility, the facility has been significantly overcrowded in recent years which indicates either that the facility is undersized for the community or probation services are inadequate for the population or both.



Mat-Su Youth Facility

MSYF provides a fully operational secure setting for juveniles from the Mat-Su District who have committed a crime and who are being detained until their cases can be investigated and processed through the courts. Opening a detention facility in the Mat-Su area allows probation and youth counselor staff to work with community service providers for placement of youth leaving the facility. The operation of this detention unit reduces the time of transit incurred by law enforcement personnel (both state and local governments), department staff, youth advocates, families and others due to not having to transport juveniles to Anchorage.



Ketchikan Regional Youth Facility

A new 10-bed facility has been constructed for the Ketchikan Regional area. The 10-bed combined facility will provide detention of youth who are awaiting court hearings or who are court ordered into this facility for a brief period of time, up to 30 days (6 beds with lock-down capabilities) and short term crises respite and stabilization services for emotionally disturbed youth (4 beds staff secure). FY2003 will be the first year that the facility operates for an entire year. It will continue to be a critical time for establishing an ongoing dialogue and coordination between the Division and an array of community providers and referral entities about the role of the non-secure mental health beds and the admission and discharge criteria. Additionally, facility managers will need to work hard to develop positive resident and staff cultures in the facility.

Explanation of FY2003 Budget Changes

The Division is mandated to protect the public, hold offenders accountable, restore victims and communities and develop offender competencies to reduce the likelihood of reoffense. A balanced and restorative justice approach to services and programming ensures that juvenile offenders take personal responsibility for repairing the harm caused to victims and communities as a result of their delinquent conduct. In FY 2003 the Division of Juvenile Justice will enter its fourth year as a separate division. Significant progress has been made since the mid-1990's to address youth facility overcrowding, although youth facility population counts remain high in Bethel and Nome. This budget proposes to annualize costs for the Ketchikan Regional Youth Facility.

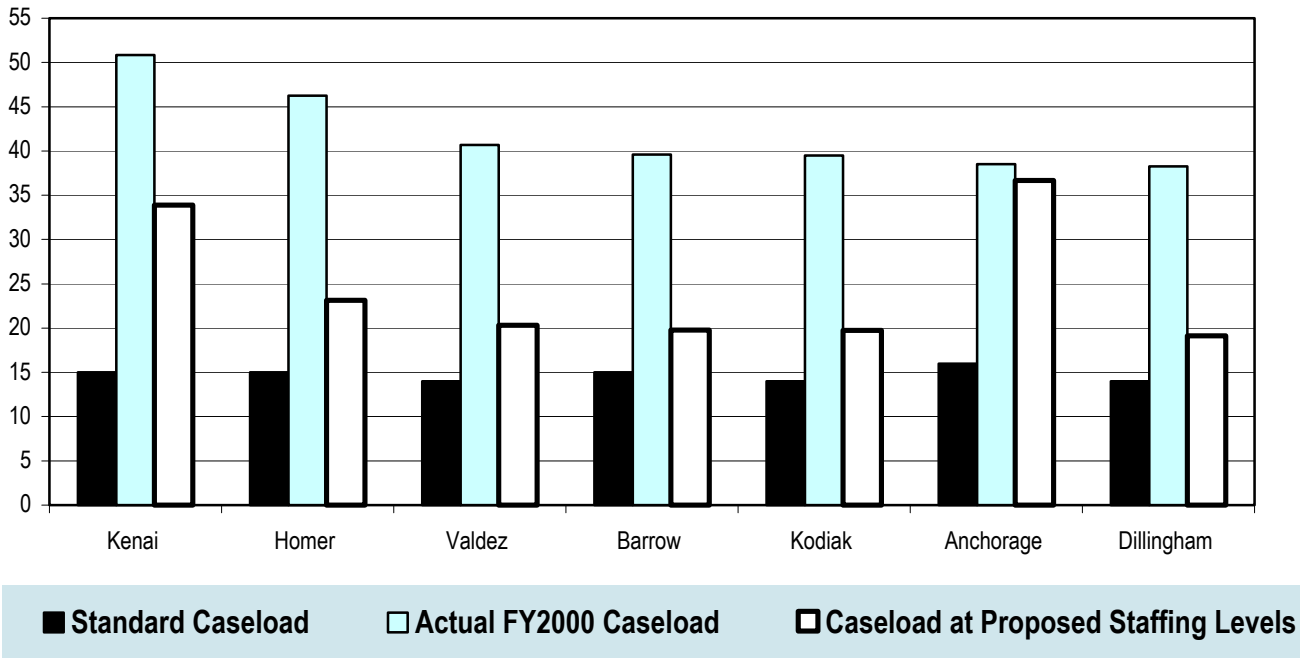
As facility overcrowding is being addressed, the Division is shifting its focus to strengthening its community probation efforts to more effectively meet the needs of communities, victims and offenders. As the Division anticipates the realities of economic restrictions, there is a compelling argument to implement community strategies now in order to mitigate conditions in the future, which might ultimately compel the state to expend enormous sums to increase youth facility bed capacity in response to juvenile crime. The strategy proposed in the FY 2003 budget is an investment with a long-term benefit, both in terms of lower youth facility funding increments and more effective programmatic impact to reduce juvenile crime rates in the years ahead. The request for 7 new juvenile probation positions ensures that our system is able to provide timely and effective front-end responses to juvenile crime, ultimately resulting in safer communities.

Juvenile Accountability and Victim Services
A request of $500.0 General Funds would address the first year of a two-year initiative. This initiative is a simple, straightforward strategy designed to confront and correct delinquent behavior at its inception where minimum effort produces maximum return. Additional early accountability resources are needed to provide immediate responses as a way to keep young offenders from becoming chronic, habitual delinquents who prey on victims and communities. The increment needed to implement this two-year strategic plan is small compared to the costs associated with constructing and staffing a new youth facility. In tangible terms, this strategy is most easily understood in terms of its impact on juvenile probation officer time available to provide swift and effective service to victims, communities and offenders. The most distinctive benefits realized as a result of the coordinated services provided by juvenile probation staff are safer communities, more satisfied victims and juveniles less likely to commit additional crime.

Holding Juvenile Offenders Accountable For Their Behavior

- Case audits show many probation offices meeting less that 50% of their required contact standards with juvenile offenders, thus placing community safety in jeopardy
- Public expectations have increased through changes in the State Constitution and statutory changes
- Lack of supervision of adjudicated delinquents on probation increases the level of risk to the public
- High incidence of alcohol, drug, mental health, and violence related offenses
- Interventions are delayed which may lead to higher re-offense rates
- Referrals to community support agencies who provide services to offenders, families, and victims are delayed
- Without intervention offenders and families may not develop skills to prevent further law violations.

Division of Juvenile Justice
Caseload Comparison of Juvenile Probation Officers



FY2000 Caseload data is the most current data available.

High Juvenile Probation (JPO) Caseloads
The Division's efforts to hold juvenile offenders accountable for their behavior are compromised by high caseloads. Communities, families and offenders are impacted when families and juveniles don't receive the services needed to learn how to change their behavior. Juveniles are best sanctioned when they are held accountable to repair the harm they've caused to victims and communities. High caseloads are an impediment to the division's ability to hold juveniles accountable. Compounding the difficulty of high caseloads is the increasingly severe nature of juvenile offenses as well as the high incidence of alcohol, drug, mental health issues among juvenile offenders.

Public Safety and Victim Services
High JPO caseloads also impact the JPO's ability to help victims in a timely manner. A lack of supervision of adjudicated delinquents on probation increases the level of risk to the public and contributes to the likelihood of higher re-offense rates. Twenty-four hour intake screening by juvenile probation officers is vital to law enforcement and public safety activities. Adequate JPO's provides for immediate intervention for offender accountability and supports communities in their efforts to establish clear and consistent behavioral standards. Probation staff also serve as the primary point of contact for victims impacted by juvenile crime. When probation staff resources are stretched too thin, victims can be put off or might not be given adequate or complete information that will enable them to fully exercise their rights to participate in the juvenile justice process.

Annualize Funding for the Ketchikan Regional Youth Facility
This request of $110.1 General Funds provides full year funding for the Ketchikan Regional Youth Facility. The facility will open the winter of 2001. The Ketchikan Regional Youth Facility is a unique facility providing secure detention beds as well as staff-secure mental health beds in a plan that was proposed and is supported by the community of Ketchikan to meet the needs of a relatively isolated medium sized Alaska community and surrounding area.

When fully operational the facility will provide secure detention services for up to 6 residents and short-term mental health housing and assessment/stabilization services to youth experiencing a mental illness. Contracted psychiatric services will include performance of diagnostic tests, evaluations and assessments; preparation of written psychiatric evaluations; general and resident-specific consultation with medical and/or counseling staff, and prescription and review of medications for juveniles.

The regional location of the facility will enable the staff to work with residents of Ketchikan and the surrounding communities of Prince of Whales Island without transporting them to Juneau which enhances the services to the residents and provides access to and for families.

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Division of Public Health

Mission

The mission of the Division of Public Health is to preserve and promote the state's public health.

Introduction

The Division of Public Health promotes the health and quality of life of all Alaskans by preventing and controlling epidemics and the spread of disease, responding to disasters and assisting communities in recovery, preventing injuries, promoting and encouraging healthy behaviors and choices, enhancing access to appropriate health care, preventing birth defects and providing services to minimize impact of disabilities and illness in the population, especially in young children. The Division carries out its mission through a range of activities and services centered on the core public health functions of health assessment, policy development and assurance.

The Division's activities and services are primarily "population-based" and focus on achieving and preserving the health and well-being of entire communities or populations rather than on the provision of medical care for individuals. The Division's professional staff monitor and assess the health status of Alaskans through the collection and analysis of vital statistics, risk factor data, and data on disease and injury. The Division uses this data and other scientific information and expertise to develop, implement and evaluate strategies, programs and services to inform the public and advise policy makers about health issues. These activities enable citizens and policy makers to make sound policy decisions to prevent and reduce health problems, promote good health and avoid costs.

The Division has been working on bioterrorism preparedness for several years. This effort intensified with the events of September 11, 2001 and the subsequent anthrax attacks. Efforts in a number of areas are essential to improve public health's readiness for a potential event in Alaska. Enhanced disease monitoring and reporting systems, improving the readiness of private health care providers, and expanding public health laboratory and communications capacity, are examples of work needed to ensure the Division's ability to identify and respond to a bioterrorist attack.

Annual Statistical Summary of Services Provided in FY 2001

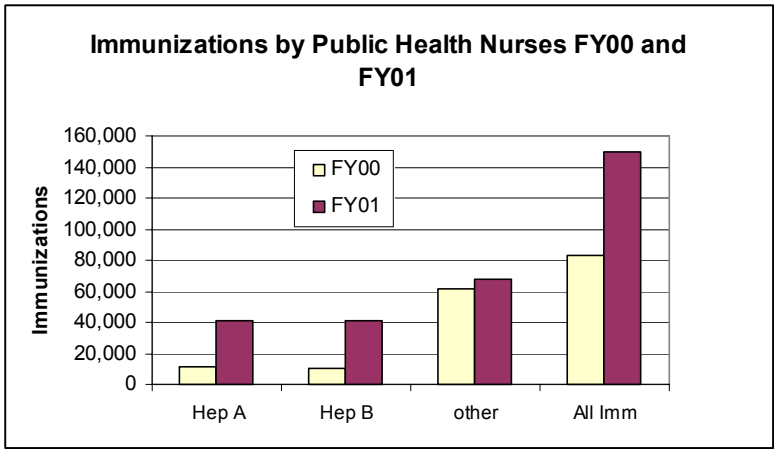
The numbers presented in this section serve only as examples of the services received by the 626,932 Alaskans, the approximately two million visitors and the nearly 70,000 non-residents who worked in Alaska in FY 2001. We estimate that approximately 30% of all Alaskans and many of our visitors and seasonal workers had a direct contact with the Division through our staff or one of our grantees or contractors during FY 01. However, we are certain the health and well-being of everyone who lived in or visited Alaska during this past year was impacted positively as a result of our efforts.

Many of the services and programs delivered by the Division of Public Health serve the population as a whole, rather than individuals, so statistics on individualized services do not portray a complete picture of the work of public health. Activities such as disease outbreak response, preparation and dissemination of epidemiology bulletins to all health practitioners in the state, planning and development of health systems and educational campaigns such as those developed to influence children not to smoke, are but a few examples of public health efforts to improve and promote the health of hundreds of thousands of Alaskans every day. Examples of some of the services provided by the Division of Public Health in FY 01 that are relatively easy to quantify are provided below.

Public Health Nursing

Public Health Nurses (PHNs) work to address public health concerns at the community level through activities such as assuring that children and adults are immunized, conducting communicable disease control investigations, helping communities solve health problems such as injuries and family violence, and providing health services not otherwise available (e.g., well-child exams provided in communities that do not have a local, private health care practitioner). Examples of services provided by PHNs in FY 01 include:

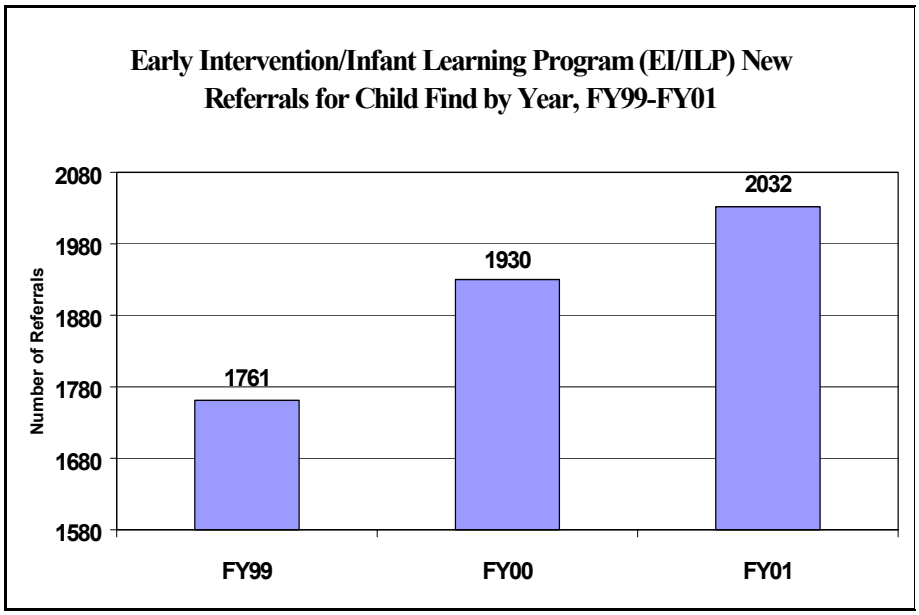
Health Care Visits Provided	167,496
Individuals Served	87,654
Total Doses of Vaccine Administered	149,871
Hepatitis A& B Immunizations Given (included in total doses above)	81,733
Pap Smears provided by PHNs	3,939
TB Tests Provided	40,060



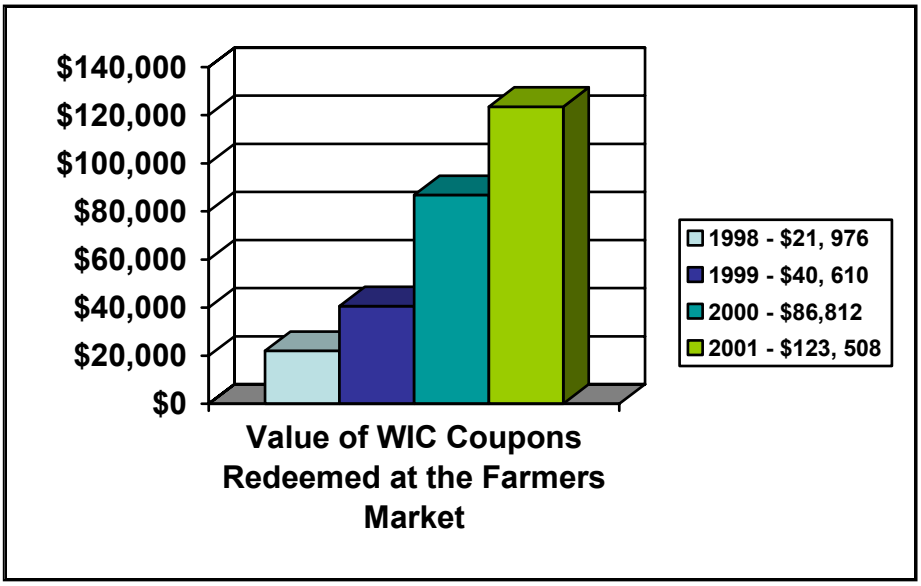
Maternal, Child & Family Health

The Section of Maternal, Child & Family Health works to develop systems of care for children, women and families. MCFH staff and grantees provide services through a variety of programs, as well as collecting and disseminating information regarding the health and well-being of women, children and families. Examples of services supported or facilitated by MCFH in FY 01 include:

- Children seen in specialty clinics (cleft lip and palate, neurodevelopmental, cardiac and genetics) 598
- Infants and toddlers enrolled and served by Infant Learning Program grantees 1,737
- Infants and toddlers identified and referred for infant learning evaluation/service by Early Intervention Child Find 2,032



- Children (under age 21) receiving preventive health exams under Medicaid (EPSDT) 34,961
- Reports to the Alaska Birth Defects Registry (2000) 11,245
- Women screened by the Breast and Cervical Cancer Early Detection Program 4,502
- Teens receiving Abstinence Only sex education 2,173
- Low-income women and teens provided family planning services 7,559
- Approximate number of low-income pregnant or breast-feeding women, infants and children under 5 years of age who received nutritious foods and nutrition education through the Supplemental Food and Nutrition Education Program for Women, Infants and Children (WIC) 25,000
- Number of WIC participants and seniors provided fresh fruits and vegetables by local farmers through the Farmers Market Program 14,519



Epidemiology

The Section of Epidemiology provides medical direction and consultation for infectious disease control, performs epidemiological investigation and follow-up on disease outbreaks of all kinds, and collects and analyzes disease reports to determine the best course of action for reducing the burden of disease and injury in Alaska.

For CY 2000 (CY 2001 numbers not yet available)

Cases of Tuberculosis –management/consultation	108
Individuals Provided Tuberculosis Preventive Therapy	873
Tuberculosis Specimens Diagnosed/Needing follow-up	7,460
Infectious Disease Reports Handled	4,446

For CY 2001

Number of Immunizations Distributed and Tracked	610,676
Number of Doses of Rabies Vaccine Distributed	62,150

Community Health & Emergency Medical Services

The Section of Community Health and Emergency Medical Services provides education, testing and support services to the emergency medical providers in the state; supports the development and delivery of primary care services in rural Alaska; assists rural hospitals in remaining viable; supports health education and health promotion activities; and conducts surveys to determine health behaviors of Alaskans. An example of services provided in FY 01 include:

Emergency Medical Technicians tested and certified	1,788
EMT classes reviewed and approved	686
Rural hospitals provided technical assistance	10
New communities receiving federally funded community health center grants with assistance and support from CHEMS	14
Homes provided with smoke alarms	5,261
Alaskans surveyed through the Behavioral Risk Factor Surveillance System	2,862
Alaska Health Fairs supported statewide	150
Cholesterol tests provided at Alaska Health Fairs	10,000
Blood pressure screenings and other tests provided at health fairs	40,500
Alaskans receiving Quit Kits and counseling to stop tobacco use	760
Communities served through local tobacco control and prevention initiatives	100
Health care providers trained to assess tobacco use and provide tobacco cessation counseling for patients	237
Sting operations to deter businesses from selling tobacco to minors	310
Medical and health services students placed in clinical training sites in underserved areas of Alaska through the Alaskan Exposure Program	35

Bureau of Vital Statistics
The Bureau of Vital Statistics handles registration, certification and protection of permanent records of vital events (births, deaths, marriage, divorce and adoption). It makes copies of these records available per the law and sells/issues Heritage Birth and Marriage Certificates to provide funding for the Children's Trust. Examples of services provided in FY 01:

Registered

Births	9,887
Deaths	2,876
Marriages	5,209
Divorces	2,306
Birth, death, marriage and divorce certificates issued	53,278
Adoptions of Alaska born children processed	875
Establishments of paternity for Alaskan born children processed	2,964
Funds generated for the Children's Trust	$21,025
Applications for the medical marijuana registry processed	176

Public Health Laboratories
The Section of Laboratories provides analytical and technical laboratory testing and information to support disease prevention programs, services and activities. The Anchorage laboratory provides bacterial testing and the Fairbanks Laboratory provides viral testing capacity.

In FY 01 the Anchorage Lab moved into a new state-of-the-art laboratory facility. This move expanded capacity by providing the ability to do Biological Safety Level 3 and molecular analysis-based tests (e.g., anthrax and plague culture, real-time polymerase chain reaction detection of infectious agents, pulse-filed gel electrophoresis to fingerprint outbreaks, non-radiometric detection of tuberculosis).

Examples of services provided in FY 01 include:

Total number of specimens received in the Anchorage Lab*	53,892
Tests for hepatitis A, B and C	20,664
Tests for tuberculosis	12,968
Sexually transmitted disease screening tests completed	35,657
Lab tests related to bioterrorist threat (calendar year 2001)	345

*More than one test may be done per specimen and some tests were completed in the Fairbanks Lab-thus more tests than specimens. A lack of computerized tracking capability at the Fairbanks Labs makes determining total specimens received by them difficult to obtain without time-consuming hand tabulation.

State Medical Examiner

The Office of the State Medical Examiner is responsible for conducting the medical/legal investigative work related to unanticipated, sudden or violent deaths. This includes determining cause and manner of death, providing consultation to law enforcement and the courts and providing information about non-lethal injuries to children specific to child abuse and neglect. Examples of services provided in FY 01 include:

Total number of bodies handled (autopsied, inspected or provided consultation)	988
Autopsies performed	304
Inspection cases	70
Consult cases	614

List of Primary Programs and Statutory Responsibilities

Public Health Nursing AS 18.05; AS 18.15; AS 44.29
Public Health Nurses serve as the front line workforce of public health at the local level, providing a variety of services. Public health nursing collaborates with the division's sections of epidemiology and public health laboratories, as well as with local health care providers to control communicable disease outbreaks.

Direct clinical and preventive services are provided in 20 community public health centers, and through visits to communities and families statewide (through contracts in the Municipality of Anchorage, Northwest Arctic Borough, North Slope Borough and Nome Census Area).

Epidemiology AS 18.05; AS 18.15; AS 44.29
Surveillance, epidemic response, investigation, and control of acute and chronic diseases and injuries are the major responsibilities of the epidemiology programs. They provide a basis for policy development by defining and identifying causal factors of disease and injury.

Public Health Laboratory AS 18.05; AS 18.15; AS 18.60; AS 44.29
The State Public Health Laboratories provide analytical and technical laboratory testing and information in support of state and national public health disease prevention programs. This is a first line of defense in the rapid recognition and prevention of the spread of communicable diseases.

Bureau of Vital Statistics AS 17.37; AS 18.05; AS 18.50; AS 44.29
The Bureau handles registration, certification, and protection of permanent records of vital events (births, deaths, marriage, divorce, adoption).

Community Health and Emergency Medical Services AS 18.05; AS 18.08; AS 18.15; AS 18.25; AS 18.28; AS 44.29
Community Health and Emergency Medical Services consists of three programmatic units: the EMS and Injury Prevention Unit strives to ensure that qualified and properly equipped emergency medical services personnel are available to respond to emergency medical needs and whenever possible, to prevent injuries from occurring in the first place. The Health Promotion Unit is dedicated to expanding the capacity of community-based health initiatives that are aimed at preventing the leading causes of death in Alaska and promoting the health of all Alaskans. The Primary Care and Rural Health Unit focuses on improving access to primary health care services for rural and underserved populations.

Health Information and System Support AS 18.05; AS 44.29
Through this unit, the Division provides health status and health system information to support state and community level health system planning, program development, and evaluation. Specific projects include developing and managing the Healthy Alaskans 2010 program and the Alaska Public Health Improvement Process

Maternal, Child and Family Health AS 18.05; AS 44.29
Public health has specific responsibilities for improving the health of Alaskan mothers, infants, children and adolescents. A variety of programmatic activities assure health services access for women, infants, children and adolescents, and other populations such as those who are low-income, chronically ill or have other special needs. Additionally, they manage directly, or through grants and consultation, a variety of maternal and child health programs and services such as MCH epidemiology, nutrition services, child health, and the Alaska Family Violence Prevention Project

Medical Examine AS 12.65; AS 18.05; AS 18.15; AS 44.29
As a key element of the public health strategies to prevent injury, disease and death, the Office of the Medical Examiner designs and manages a statewide system of medical legal investigation of unanticipated, sudden, or violent deaths. Activities include providing accurate, legally defensible determination of the cause and manner of deaths; and, conducting comprehensive medical legal death investigations.

The Division of Public Health continues to focus on its historical role of monitoring the health and well-being of Alaskans, assisting communities, families and individuals in preventing disease and injury, identifying and responding to outbreaks of disease and minimizing their impact and providing information to policy makers and others to facilitate the most effective use of scarce health care resources. In addition to these traditional activities, many of the staff and services have had to be expanded and enhanced in order to respond in a timely and appropriate manner to the terrorist threats that Alaska and the rest of the country continue to experience.

FY 2003 budget changes for the Division are in two separate budgets. One is the Homeland Security Budget and the other is the regular State Operating Budget. The changes being requested are described by component and increment within each budget.

Public Health Nursing in Bethel Needs an Adequate Facility
Public Health Nursing staff in Bethel is currently operating out of a very inadequate leased facility. $259.0 GF and $226.8 I/A Rcpts is being requested to annualize the lease costs that are expected for FY03. In FY 02 partial funds were provided but due to miscalculations related to space needs and costs, the amount requested did not represent six months of real costs. A build to suit facility is currently being procured by DHSS and it is believed this additional lease support will be adequate to pay for the facility that will be both large enough and appropriate for the delivery of clinical nursing services to Bethel and the YK Delta.

Foster Children Need Additional Support In Order To Obtain Essential Health Care
Public Health Nursing is requesting an increment of $434.7 I/A and $145.1 GF to cover the costs of implementing the Health Passport Program in Mat-Su, Kenai, Fairbanks, Bethel, Juneau and enhancing the program in Anchorage. This program is a collaborative effort of DPH, DMA and DFYS to improve the health status of children in foster care, a group that has consistently been identified as receiving less adequate health care compared to children not in foster care. This program, which was piloted by one nurse in Anchorage, establishes a health record, which stays with the child while they are in state custody and provides nursing support and consultation to both foster parents and social workers.

WIC Needs Additional Authority to serve Participants and Expand the Farmers Market Program
The Women, Infants and Children (WIC) program is requesting an additional $1,200.0 Federal Authority and $78.4 GF to support the WIC program and enhance the Senior Farmers Market program within the state. $500.0 of the authority is needed to cover increased costs of nutrition education and service delivery at the local level. The money to provide these services is awarded to community level grantees who deliver the program at the local level. $750.0 is for WIC and Farmer's Market food expenditures and $28.4 is needed to produce educational materials and recipe cards. The WIC program provides supplemental foods and nutrition education to at risk pregnant and breastfeeding women, infants and young children and the WIC and Senior Farmers Market programs provide fresh fruits and vegetables to the same groups and low-income Seniors, while simultaneously supporting small farmers in such areas as Fairbanks and the Mat-Su Valley.

Alaska Birth Defects Registry is Critical and Needs General Fund Support
The Maternal Child and Family Health (MCFH) Section is requesting a fund source change of $150.0 from Federal to GF for the Alaska Birth Defects Registry, to allow this currently federally funded and essential surveillance system to continue. This registry is essential to determining Fetal Alcohol

Syndrome and other birth defects in order to ensure services are available and to measure the impact of intervention efforts over time.

Additional I/A Authority is needed to Conduct a Pediatric Oral Health Assessment
MCFH is also requesting an increase of $300.0 I/A authority in order to receive expected funding from the University of Alaska to conduct a children's oral health needs assessment. Young Alaskan children suffer extremely high rates of tooth decay and other oral health problems. It is essential that the extent and location of the problems be identified in order to better provide and direct the needed services.

Increased GF/Program Receipt Authority is Needed to Collect and Use All Fees
MCFH's final request is for $100.0 GF/Program Receipts, so the Specialty Clinics operated by the Section can collect and use all receipts generated by the clinics and the newborn metabolic screening program on behalf of the children needing special medical services. Currently specialty clinic services must be limited due to inadequate funding to purchase/pay for them. The additional authority will make it possible for the clinics to retain all the fees generated and then offer additional/enhanced services to the special needs children who need them and are currently not receiving them due to lack of funding.

DPH must monitor the effect on Alaskans of Consuming Local Fish and Sea Mammals
The Epidemiology Section is requesting $200.0 GF to establish a basic Environmental Contaminants Evaluation and Monitoring program specific to the impact on Alaskans related to consuming subsistence and recreationally obtained fish and seafood. Alaskans want to know if our food is safe to eat. Federal agencies such as the Food and Drug Administration and the Environmental Protection Agency are issuing fish consumption advisories for the nation, based on analysis done on fish mostly caught east of the Mississippi River. Alaska must continually monitor our fish to determine if we can continue the current recommendations for Alaskans, which do not restrict fish consumption for pregnant women and young children due to the much lower levels of possible contaminants. Current efforts are funded by time and use limited federal grants. These funds would support one full time staff person to coordinate and oversee the activities related to human consumption of fish and sea mammals exposed to contaminants. This will ensure that this work will be maintained at a minimal level should federal grant dollars cease.

Children's Health Status and Efforts to Improve It Must be Monitored and Reported
The Health Information and Systems Support Unit is requesting $90.0 GF to establish a full time Child Health Indicators Project research analyst position and pay for costs related to collecting and disseminating the information collected. Children are the most vulnerable to environmental and societal changes. Being able to closely monitor, record and report the overall health and well being of Alaskan children will enable the state to determine which intervention efforts are working and where emerging problems need attention.

Additional Authority is Needed to Receive Funds to Enhance Tobacco Enforcement Efforts related to Selling Products to Minors
The Section of Community Health and Emergency Medical Services (CHEMS) is requesting $100.0 of receipt services authority. As a result of legislation passed last year tobacco endorsement fees were increased to assist in the costs related to enforcement of laws forbidding sales of tobacco products to minors. This authority will allow the section to receive and use the increased revenue for this purpose.

Additional Funding is needed to pay Operating Costs for EMS Telecommunications
The CHEMS Section is requesting $50.0 GF to assist in paying for the dramatically increased costs charged by the Department of Administration for maintaining and operating the state's emergency medical services telecommunications equipment. The cost of this service has risen from $142.9 in 1996 to $271.0 in 2001. This increase will offset a portion of these costs.

ILP Programs Need Additional Funding to Provide Enhanced Services/Retain Staff
The Infant Learning Program Grants component needs an additional $200.0 GF/MH in order to enhance the early intervention/infant learning services for young children with disabilities or at high risk for developing them. These dollars will assist in keeping qualified teachers, increase services for children in rural areas and expand services to children experiencing congenital hearing loss. Currently ILP teachers are leaving the program for higher paying positions elsewhere in the community. Training costs are increasing and therapy services remain inadequate.

Additional Funds are Needed for Tobacco Prevention and Control Efforts
The Tobacco Prevention and Control component needs a $4,123.9 increase in tobacco settlement dollars to more adequately develop and implement a comprehensive prevention and control program statewide. These dollars would go primarily for more community and school programs, additional cessation efforts, more counter-marketing campaigns, and additional program development and evaluation. This increment will make available a larger portion of the 20% set aside of the Master Settlement Agreement to counteract the aggressive work of the tobacco companies to both attract new smokers and keep current smokers addicted.

The Division of Public Health works hard to obtain and utilize federal grant dollars to meet the health needs of Alaskans. However, a certain very basic level of infrastructure must be maintained with general fund dollars in order to maintain the ability to write the grants and administer the federal grant funds and also to pay those essential costs for which no grant funds are available.

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Public Health Nursing is the local public health presence

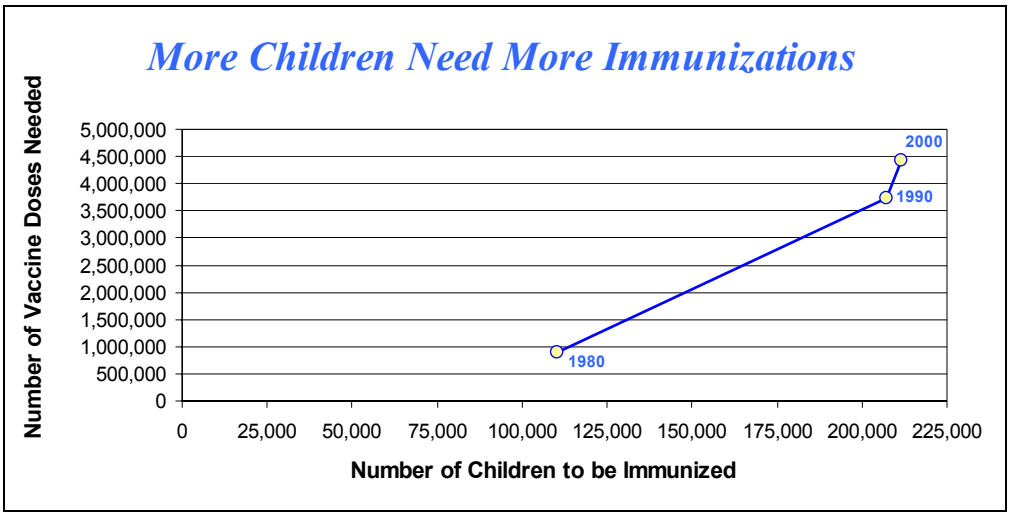
Public Health Nursing provides the public health presence at the local level in most communities in Alaska. Therefore, whether it is a naturally occurring disease outbreak or one resulting from a terrorist act, adequate numbers of trained and experienced public health nurses are essential to both assist in detection and in controlling the impact of such events. In last year's Back to Basics request we asked for additional nurses to increase our overall capacity at the local level. We received about one-third of that request and hired several additional staff. We are now requesting an additional $450.0 GF to support an additional six nurses and the related travel and operational costs necessary for them to carry out their duties. This will not fully fund the nursing capacity we need, but will continue to enhance it. $134.0 GF is being requested to support one nurse specialist and a support person to focus exclusively on training and supporting the public health nurses to be ready to respond to any terrorist attack, with a special focus on bioterrorism. These staff will research new information to ensure it is quickly and consistently disseminated and will translate that research into training and reference materials easily used by staff statewide. Since communication at all levels is critical during any disease outbreak but especially important during a terrorist attack, $150.2 GF is being requested to support two additional computer support staff to keep the computer communication system within public health nursing operational and upgraded when required.

Epidemiologists provide essential medical consultation and support

The Section of Epidemiology provides the medical consultation, clinical oversight and direction to physicians and nurses providing direct care to patients and those managing and controlling disease outbreaks. Additionally they collect and analyze the data needed to determine the disease load in the state and effectiveness of disease control measures. The $450.0 GF that was not funded through the Back to Basics request last year is again being requested to support three nurse epidemiologists, an analyst programmer and the operational and travel costs related to their work. These staff would be critical in the event of a biological terrorist attack and can greatly enhance the state's ability to control disease spread on an on-going basis. An additional $258.0 GF is being requested to hire a full time physician epidemiologist and a nurse epidemiologist who would become the Epi experts both clinically and epidemiologically for both biological and chemical terrorism. These dollars would also support their travel and training needs.

Essential Drugs and Vaccines Need Oversight and Management

The state immunization program has grown dramatically in recent years with the addition of many new vaccines and increasingly complex immunization schedules. There is a need for pharmaceutical consultation to consistently monitor the location and availability of drugs which would be needed in response to an attack using a variety of biological agents. Thus, a pharmacist is needed to manage the acceptance and dispersal of the federal pharmaceutical drug pacs in the event of a major attack and day to day drug related questions and concerns and $104.8 is being requested to fund one full time public health pharmacist. Since additional medical expertise would also be needed in the event of an actual attack and would be helpful in designing and managing drills, $30.0 GF is being requested to have physicians on contract for immediate response and assistance.



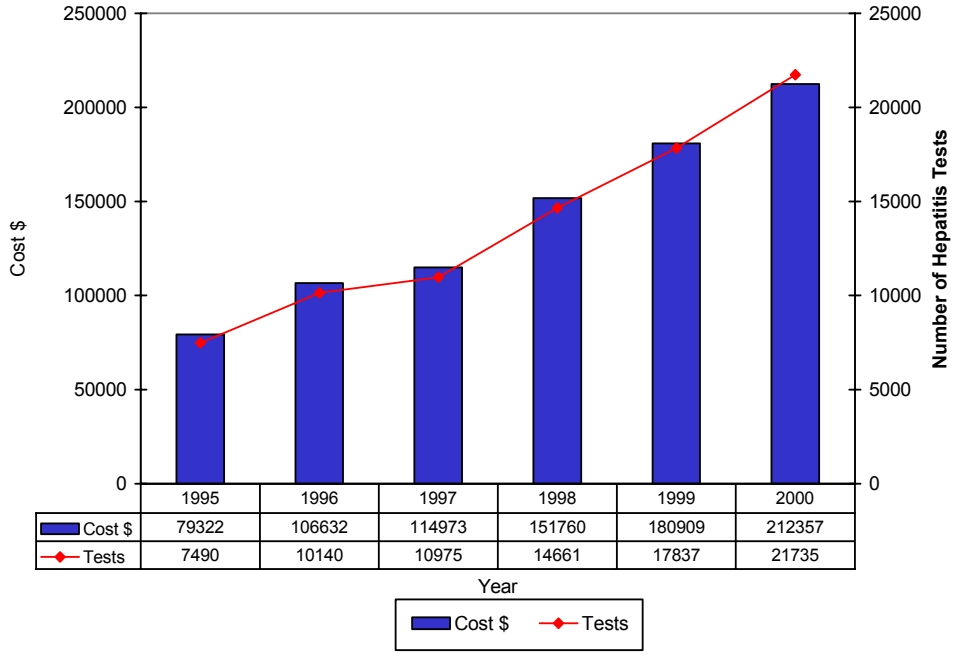
Enhanced Communication and Information Systems are Critical
The Section of Community Health and Emergency Medical Services is requesting $157.5 GF to support hiring an analyst programmer and a data entry clerk to support the Health Alert Network, which is the system responsible for rapid electronic communication in the event of a disaster or other public health emergency. $111.0 GF is being requested to support the salary, travel and contractual costs related to hiring a disaster communications specialist whose job will be to ensure public health communications systems are adequate, well maintained and capable of interacting with the systems used by partner agencies at the local, state and federal levels. A well designed and maintained communications system is essential to both respond to a terrorist attack and to detect and respond to more everyday health issues and problems.

Local First Responders Need Essential Training and Updating
The Regional Emergency Medical Services grantees are critical partners in assuring that any natural occurring disaster or one intentionally inflicted on Alaskans can be responded to quickly and competently. $330.0 GF is being requested to support the costs associated with these grantees being able to obtain the specialized training, do the response planning and drills and implement the overall system enhancements that are essential to being prepared for a terrorist attack.

Public Health Laboratories must be well equipped and fully staffed
The Public Health Laboratories played a major role in responding to the anthrax scares the last part of calendar year 2001 and continue on. The remainder of the Back to Basics request from last year, $240.0 GF is being requested. This will fund one additional microbiologist and costs related to shipping and disposing of specimens and a minimum amount of test kits and materials. $608.0 is being requested primarily to pay the additional salary costs related to having to upgrade the microbiologists' salaries in order to recruit and retain them in the Anchorage lab. When the large influx of specimens began in early October the lab had a 47% microbiologist vacancy rate and simultaneously had to turn what had been a 5 days a week/8 hours a day lab into a 7 days a week/24 hours a day lab, with existing staff. The remainder of the funding is for supplies and related costs.

Both the Anchorage Lab and the State Medical Examiner's Office, which are co-located, need additional computer network support, if they are to be capable of communicating and responding with all related agencies in the event of an attack. $80.0 is being requested to fund a computer network specialist to serve both agencies. This capacity will also enhance communication on routine matters.

$191.3 GF is being requested to hire an additional microbiologist in both Anchorage and Fairbanks. At the current time only Fairbanks can do virology testing and only Anchorage bacterial tests. These additional staff will allow for cross training to ensure that both labs can do both types of test in the event one lab is rendered unusable or the surge of tests is such that both labs will be needed to perform either bacterial or virology testing. The supply budget for test materials was inadequate prior to the influx of testing needed as a result of the anthrax concerns. $300.0 GF is being requested to provide $100.0 for FY02 and $200.0 for FY03 to ensure there are adequate test kits and other materials to do both the regular tests that are requested as well as the additional tests related to bioterrorism threats and concerns. Additionally new tests are being made available on an on-going basis and they are increasingly expensive. Cost of testing has gone up dramatically in recent years. For example, the cost for hepatitis testing has more than doubled in the past five years:



Homeland Security Funding enhances the public health infrastructure

It is critically important that everyone understand the staff and operational cost increments being requested in the Homeland Security budget will not only ensure that Public Health is better prepared to detect and respond to a terrorist attack but will also provide major returns in terms of increased disease detection, intervention and long term prevention for those diseases that have caused great suffering and incurred major health care costs for the past many decades.

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Division of Alcoholism and Drug Abuse

Mission

To promote the health and well being of Alaska's citizens by preventing and treating alcohol, other drug and inhalant abuse.

Introduction

The Division provides prevention and treatment services through a variety of grants to support community-based substance abuse services. These services are provided through a statewide network of local and regional non-profit organizations and governments. The two-year grants are awarded through a competitive process. The grantees are required to have a minimum 10 percent match for all state awarded funds.

The types of services provided through these grants are:

- Treatment
  - Outpatient Services
  - Diagnostic Clinics
  - Medical and Social Detoxification
  - Women's and Children's Services
  - Long Term Residential Services
  - Short Term Residential Services
  - Prison Treatment Services
  - Rural Treatment Services
  - Inhalant Services
  - Drug Services
  - Continuing Care and Follow-up
  - Outreach Programs
- Prevention
  - Consultation and Education
  - Rural Prevention Services
  - Urban Prevention Services
- Alcohol Safety Action Program
- Services for Co-Occurring Disorders (Dual Diagnosis)
- Rural Human Services Training Program
- Community-Based Suicide Prevention Program

According to the McDowell Group study of the "Economic Costs of Alcohol and Other Drug Abuse in Alaska" that was released on November 13, 2001, the cost to the Alaska economy was $614 million in productivity loss (52%), criminal justice and protective services (24%), health care (20%), traffic crashes (3%) and public assistance (1%). The average annual number of deaths attributed to alcohol and other drug abuse for the years 1994-1998 was 224.2.

Alcoholism and drug abuse are societal problems that affect everyone whether you are the person with the disease, the spouse or child of an abuser, the police officer who takes you into protective custody, the employer who cannot meet deadlines because of the employee's inability to show-up for work, the child who will never be normal because his/her mother drank while pregnant or the family who is mourning because a family member was killed by a drunk driver. Alcoholism and drug abuse swells our prison population. Substance abuse costs for the criminal justice system and protective services cost the state $146 million in 1999. Another $123 million was spent on health care. And yet there is no cost that can be associated with the emotional drain that this problem places on individual Alaskans.

The division is responsible for collecting information on the nature, extent, causes, and consequences of substance abuse in Alaska, the effectiveness of prevention and treatment services and increasing public understanding of causes, effects, and treatment options. The division also has the responsibility to develop, implement, and support an effective community-based system of services for prevention and treating substance abuse among Alaska's diverse population, and to establish and administer standards for these services.

The Division has four offices. The Director's office is responsible for program and policy development, substance abuse prevention services, training coordination, grants management, quality assurance and providing for statewide data collection through the Management Information System (MIS).

The DHSS Office of Fetal Alcohol Syndrome (FAS) located in Juneau received a federal Substance Abuse and Mental Health Services Administration (SAMHSA) grant award of $5.8 million per year for five years [FY01-FY05]. The federal project is a comprehensive, integrated approach to focus on the prevention of fetal alcohol syndrome and other alcohol-related birth defects and to improve the delivery of services to those individuals already affected by alcohol-related birth defects. Throughout the project period, a number of community-based grant programs will be solicited and funded from the Office of FAS.

The Anchorage field office is responsible for oversight of state-approved treatment programs including program approval and technical assistance, and for certifying both grantee and private facilities. Alcohol and Drug Information Schools are also monitored and approved through this office.

The Division also has the Anchorage Alcohol Safety Action Program (ASAP). The basic ASAP function is to provide case management and accountability for DWI and other alcohol and drug related misdemeanor cases. This involves screening cases referred from the district court into drinker classification categories, as well as managing and monitoring cases throughout education and/or treatment requirements. In addition Anchorage ASAP staff is responsible for statewide quality assurance, training, providing for statewide data collection through the ASAP MIS, and management of the eight statewide ASAP grantees.

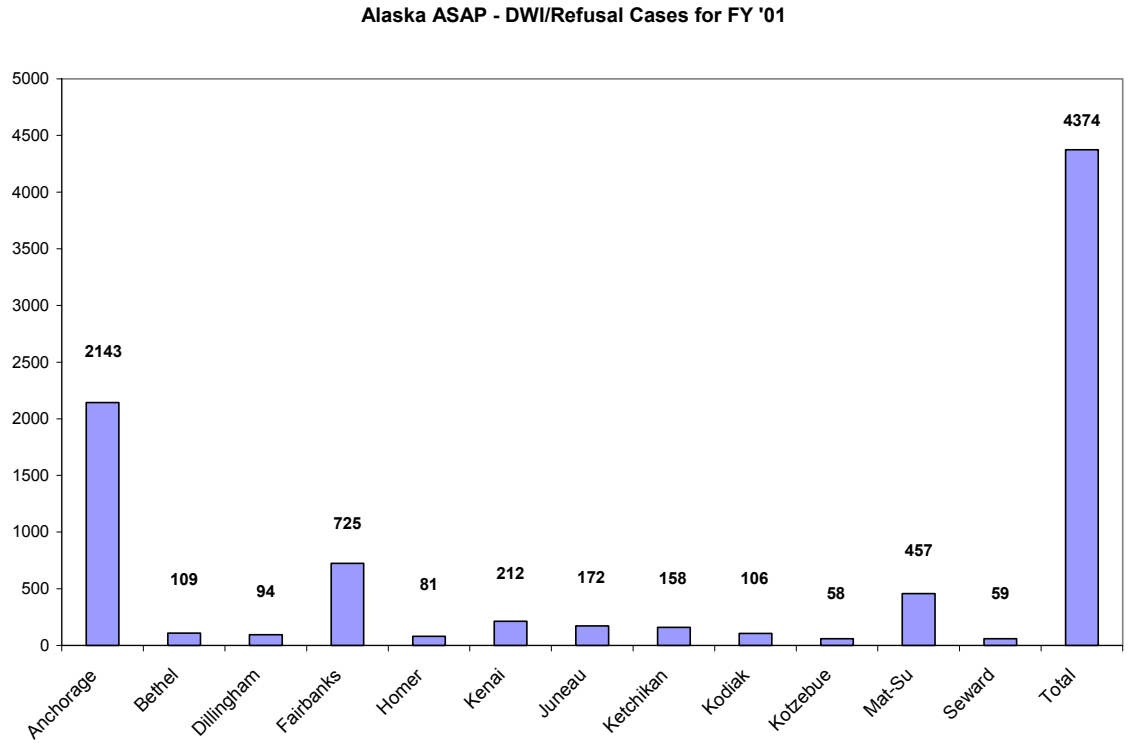
Annual Statistical Summary of Treatment Services Provided

The chart below shows selected client characteristics for all new clients admitted to **Outpatient and Residential Treatment** by ADA grantee funded programs during the fiscal years indicated. This data reflects unique clients. Data is from client admission forms submitted to the division's Management Information System.

Selected Characteristics	1999* (N=7,994)	2000* (N=7,048)	2001* (N=5,970)
	Percentage	Percentage	Percentage
Gender			
Male	64%	63%	63%
Female	36%	37%	37%
Ethnicity			
Native Alaskan	47%	46%	45%
Caucasian	43%	42%	43%
All Other	10%	12%	12%
Children in the Home			
Yes	43%	41%	40%
Age			
20 & Under	16%	15%	15%
21-34	38%	36%	36%
35-44	31%	33%	32%
45-54	11%	12%	13%
55 & Over	3%	4%	4%

* Unique Client Counts

In FY2001, there were 7,547 cases involving Driving While Intoxicated (DWI). 4,374 of these cases were referred to ASAP offices. The remaining arrests were either dismissed, convicted as a felony DWI or convicted of a misdemeanor where there is no ASAP office in the area.



List of Primary Programs and Statutory Responsibilities

AS 47.30.475 - 500 and AS 47.37
As required by AS 47.30.475 - 500 and AS 47.37 the Division provides substance abuse prevention and treatment services to all Alaskans.

Community Based Treatment Services
Emergency Care, Residential and Outpatient Treatment, Methadone Treatment (Anchorage only).

Community Prevention services
Including research based "best practices", Peer and Natural Helper Programs, local and statewide services.

Community Action Against Substance Abuse (CAASA) Prevention Grants (AS 47.37.045)

Services for Families
Residential and Outpatient Treatment for Youth, Residential and Outpatient Treatment Gender Specific for Women and their Children

Specialized Services to Rural and Native Alaskans
Community Based Suicide Prevention Projects, and the Rural Human Services Project.

Training Services
Annual Prevention Symposium, Local Option Manual, Substance Abuse Counselor Training, and Training for Clinical Supervisors and Program Managers.

Alcohol Safety Action Program (ASAP)
Statewide Coordination of Fetal Alcohol Syndrome (F.A.S.) and Alcohol Related Birth Defects (A.R.B.D.) Programs

Alcohol abuse and alcoholism is the number one social and criminal justice problem in Alaska. Recent research indicates that alcohol dependence or abuse personally affects 58,402 Alaskans. This represents almost 14% of Alaska's population aged 18 and over. Further analysis indicated that the need for treatment appears to be highest in the Bush and Southeast, and that dependency and abuse rates are found to be twice as high among men as among women. Research findings available in the Alaska Adult Household Telephone Survey.

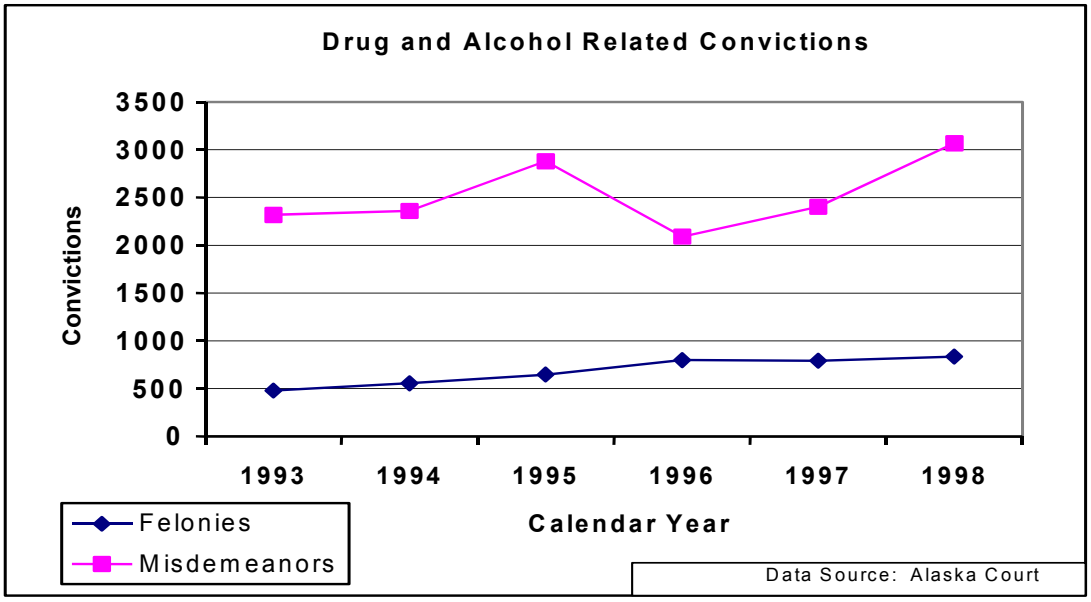
How does Alaska stack up against other states? The December 2000 National Institute on Alcohol Abuse and Alcoholism surveillance ranks Alaska in the top 10% of the nation on alcohol consumption per capita along with Delaware, Washington, DC, Nevada and New Hampshire.

Stabilization of the Alcohol Safety Action Program - $470.0 GF Increment

The Criminal Justice Assessment Commission has expressed the need to efficiently and effectively monitor misdemeanor offenders to ensure compliance with sentencing recommendations imposed by the Court. Helping the offender to complete recommended treatment increases the probability that criminal behavior will not be repeated.

The Alcohol Safety Action Program (ASAP) provides a standardized statewide network of substance abuse screening and case management of civil and criminal justice cases. ASAP operates as a neutral link between the justice and the health care delivery systems.

In FY2001 the Anchorage ASAP was responsible for providing case management and monitoring services to 4,374 new cases; FY2002 case management is estimated at 4,500 new cases. In the Alaska Criminal Justice Assessment Commission (CJAC), Final Report May 2000, the Commission strongly recommended that the legislature restore funds to ASAP and expand its monitoring ability.



This increment would establish 3 PFT positions for the Anchorage ASAP Office, and reclassify one existing position from PPT to PFT. The additional staffing would allow the office to handle the increase of referrals, eliminate current backlog of new cases, ensure timely monitoring of referrals, and provide the resources needed to effectively link clients to best and/or appropriate services and intensively monitor the "high-risk" client.

The Alaska Alcohol Safety Action Program- Institute for Circumpolar Health Efficacy Study Report conducted by Dr. Brian Saylor, University of Alaska Anchorage found that 65-66% of the clients referred to the ASAP system did not re-offend within three years of the first DWI offense.

Juvenile Alcohol Treatment Expansion - $839.1 GF
The Division of Alcoholism and Drug Abuse is putting into place a mechanism that requires minors cited for consuming or possessing alcohol to be screened and assessed for alcohol dependency. Early intervention with minors who are known to use alcohol would likely reduce future demands on both the juvenile and adult criminal justice systems. This funding would provide for treatment through grants to the existing adult ASAP programs for those juveniles assessed as needing substance abuse treatment.

The demand for alcohol treatment for youth currently exceeds the availability. All providers have waitlists. As early intervention becomes more available through the establishment of Juvenile Alcohol Safety Action Program Services, the need for treatment will become more identifiable.

Research shows that youth who begin to consume alcohol before the age of 15 are four times more likely to develop alcohol dependency than people who wait until after the age of 21 to begin drinking. In 1999 the Alaska Court System recorded over 2,200 citations for minors under the age of 18 consuming alcohol.

The Juvenile ASAP program would allow an increase in the identification of youth who are clinically diagnosed and in need of residential alcohol treatment in more communities than in the four pilot sites established in FY2002 (Ketchikan, Kotzebue, Fairbanks and Juneau).

This increment will provide $300.0 towards assessment and $539.1 towards outpatient treatment of those youth identified as needing treatment.

Eliminate Waitlist for Women with Children - $1,241.0 GF
The state programs emphasize the importance of treatment for alcoholics to control their disease. It is important that individuals be able to access treatment when the individual recognizes that they need the services. If they are placed on waiting lists, the chances are great that they will fall off the list and show up later in the system for the same or worse reason. Women are especially reluctant to enter residential treatment if it means that they will lose their children while undergoing treatment.

Program	No. On Wait list	Beds/Capacity Need	Cost
Women w/children	61	17	$1,241.0

The waiting list for women with children is 61. Two programs that would serve seven to ten women each (plus 14 - 20 children) would be able to handle this increase. If women entered the program and spent 100 days, the program could treat about 62 women in a year. Since waiting lists are dynamic and there are more women waiting for care than are on the lists, this capacity estimate is reasonable.

The operating funds are for a full year of operations in FY 03. This is based on combined operating costs of $200 a day (women treatment care, on-site daycare, and other special costs).

Funding this increment has an impact beyond the Division of Alcoholism and Drug Abuse. This increment allows a woman to enter residential treatment with her children which results in fewer children being placed in foster homes.

Maintain Anchorage Detox and Dual Diagnosis Alcohol Treatment Services – Fund Change $1,078.5 GF, ($1,078.5) Federal

Enhanced detoxification and residential dual diagnosis treatment are two of the major services under the Community Health/API replacement project. A federal grant supported these services for a limited time during the downsizing of API. These federal funds will no longer be available in FY2003. This funding supports 100% of the emergency detoxification and dual diagnosis beds in Anchorage. This consists of 15 detox beds (5 enhanced and 10 standard) as well as 12 beds for residential dual diagnosis treatment services. These community services support the downsizing of API by providing a more appropriate care and treatment alternative for persons in crisis with the dual diagnosis of mental illness and substance abuse who do not require hospitalization. Providing detoxification and dual diagnosis treatment services for a more acute population in the least restrictive environment possible saves the state the cost of unnecessary and expensive hospitalizations and shortens hospital stays.

Minimum Funding for Small Community Outpatient Treatment Programs – $1,062.0 GF

If outpatient care is not available in a community, the client is forced to leave the community and enter residential care. Given high substance abuse problems in rural areas, base capacity needs to be developed in these communities. Because local treatment is cheaper and can be culture specific, the program can reach more people and be more successful than transporting them into a regional hub or major city for treatment. This request is for funding to bring all rural sub regional hubs for substance abuse programs to a minimal level grant of $150.0.

Program Location	Current Funding	Additional Needed
Galena	$0.0	$150.0
McGrath	128.4	21.6
Craig	146.5	3.5
Valdez	10.0	140.0
Cordova	72.3	77.7
East Aleutian Tribes	72.5	77.5
Aleutian Pribilof Association	73.0	77.0
Copper Center	0.0	150.0
Wrangell	93.1	56.9
Petersburg	106.6	43.4
Nenana	77.3	72.7
Aniak	58.0	92.0
Ft. Yukon (CATG)	50.3	99.7
Total		1,062.0

This increment will give new money to two of the sub-regional hubs. Copper Center funding was deleted in prior year budget cuts. This community has a real need for alcohol treatment services, which will be addressed by this increment. Galena has not been a grantee in prior years. They have a high rate of suicides and alcoholism that needs to be addressed.

Eliminate Adult Residential Treatment Waitlist - $471.8 GF
The state programs emphasize the importance of treatment for alcoholics to control their disease. It is important that individuals be able to access treatment when the individual recognizes that they need the services. If they are placed on waiting lists, the chances are great that they will fall off the list and show up later in the system for the same or worse reason.

The waitlist has been created in part by the level funding to the grantees. As a result of inflation, the core capacity of the grantees to provide services has diminished. In FY 2001 and 2002, the grantees notified the State that they have had to lay off staff and reduce the number of beds. Should this increment not be funded, the waitlist will grow because people will not be able to get treatment.

It is estimated that the total adult residential treatment waitlist is 143, and that the split is 40% needing short-term care, 20% needing long-term care and 40% needing dual diagnosis treatment. The dual diagnosis needs are addressed in a separate increment. Short-term care can be as long as 45 days, whereas long term care may extend to 270 days for complete treatment. Based on these estimates the division is requesting $146.0 for short term and $325.8 for long term care.

The demands for treatment services are increasing. Under the Magnuson-Stevens Fishery Conservation and Management Act, the Department of Community and Business Development is working with 65 communities in western Alaska. At a recent Human Resources Conference, the human resource staff in the fish processing/harvesting industry expressed their difficulty in recruiting qualified applicants. One of the main barriers is having the applicant pass the drug and alcohol screening. DCBD is requesting assistance from the division to identify programs to assist the applicants that do not pass the initial screening. Without expanding the treatment services funding, this requirement from the fishing industry will put a burden on the already overtaxed grantees.

Statewide Dual Diagnosis Treatment - $1,442.6 GF
Currently the Division's wait list for adult residential programs stands at 143. In addition the DOC states that up to 120 persons per year are discharged needing dual diagnosis residential care. This waitlist does not distinguish between levels of care needed. Based on review of reports from Anchorage-based programs (the only community with separate dual diagnosis programs), we estimate that the split would be 40% needing short-term care, 20% needing long-term care and 40% needing dual diagnosis treatment. The long- and short-term care needs are addressed in a separate increment.

Dual diagnosis refers to those individuals with both a substance abuse and a mental health diagnosis. If we assume 40% of the waitlist would need dual diagnosis treatment plus 18 additional people treated annually, to account for DOC inmates being released who are not accounted for on the waitlist, there are an estimated 75 persons waiting for dual diagnosis treatment. Dual diagnosis residential need would be 13 beds.

This community service supports the downsizing of API by providing a more appropriate care and treatment alternative for persons in crisis with dual diagnosis. Should this increment not be approved, the number of admissions to API could increase.

Substance Abuse for Women with Children – Fund Changes $300.0 GF/MH ($300.0) MHTAAR

FY 2003 is the final year of two Mental Health Trust funded projects for substance abuse treatment for rural women with children. It is proposed that the funding for both of these be converted to GF/MH in FY03. Both programs allow women to receive treatment without having to leave their children. The first has provided for the expansion of the residential and outpatient treatment for women and children through DHSS referral. The desired result is to break the cycle of family dysfunction and abuse and decrease the risk of alcohol-affected births.

The second is a demonstration project initially funded by the Mental Health Trust. The Trust recommends continuation of this project with GF/MH funding. This project allows women to participate in day treatment while being housed in a local domestic violence shelter. Residential services and childcare from the shelter support treatment services and allow women to remain in their home community while receiving substance abuse treatment. This funding is granted to the Bristol Bay Health Corporation in Dillingham to provide these services.

Therapeutic Court Treatment Annualization - $286.4 GF

A Therapeutic Court program was established in FY02 with pilot sites in Anchorage and Bethel. With the passage of Chapter 64, the Legislature partially funded the fiscal note for FY2002 for $399.0, with only partial year funding planned for Bethel. This increment would bring both of the programs up to the full annual funding of $685.4.

Transitional Housing for Substance Abusers - $250.0 GF, $300.0 MHTAAR

Individuals returning to smaller communities from out-of-town treatment programs are at risk of losing their sobriety without adequate community-based supports. Transitional housing will provide safe and sober housing following treatment completion. The Division will collaborate with community agencies to combine appropriate housing resources. Transitional housing will permit individuals to reunite with their families more quickly and to practice their new recovery skills in their old, familiar environment before returning home.

In FY2001 the Legislature appropriated $282.0 in capital funds and in FY2002 $200.0 for start up operating funds. This increment will fund the operational portion of this program for a full year.

Inhalant Abuse Prevention - $470.0 GF

The Alaska Bureau of Vital Statistics can identify one death per year for the period 1995 through 1998 and 2 deaths per year for 1999 and 2000 that could be attributed to inhalant abuse. There may be more as the person who certifies the Death Certificate may identify some other cause that is not ordinarily associated with inhalant abuse, and some deaths involving inhalants may be listed as auto accidents or suicides.

Inhalants are breathable chemicals that produce mind-altering vapors. Inhalants include such items as spray paints, gasoline, oil and grease dissolvers, paint thinners, whipping cream, typing correction fluid, room fresheners, glue, hair spray, white board markers, and fabric protectors. There are more than 1,400 products that are sold as part of everyone's normal life that are used by inhalant abusers. Many of these products are free or relatively inexpensive which makes them attractive to the younger set. The youth do not have to go through a "dealer" in order to obtain these products. They are readily available at home, school, convenience and grocery stores, and hardware and auto supply stores.

Inhalant abuse has joined alcohol and marijuana as one of the top three drugs of choice among children of grade-school age. One in five students in America has used an inhalant to get high by the time he reaches the eighth grade. Nationally, 29% of those who use inhalants said they started before their 10th birthday. It is believed that Alaska exceeds the national rates. Communities don't know the deadly effects the poisons in these products have on the brain and body when they are inhaled or "huffed", "sniffed" or "wanged". It's like playing Russian roulette. The user can die the 1st, 10th or 100th time a product is misused as an inhalant. It is also unknown how many people have ended up with severe, permanent disabilities. Bright, articulate individuals end up in group homes having to re-learn how to take care of themselves after going into an inhalant-induced coma.

The Division of Alcoholism and Drug Abuse proposes an initiative supporting action at the community level to prevent inhalant use and intervene effectively when it occurs. Under this initiative communities would receive grants to implement community-specific prevention and intervention strategies that adapt "best practices" approaches, those which have proven effectiveness, to individual community circumstances.

The project will focus on nine to twelve communities each year, selecting those with the greatest need and readiness for effective action for training and support. During the first year of project implementation, the division will also develop "tool boxes" containing information and guidance needed to assist communities in implementing particular strategies.

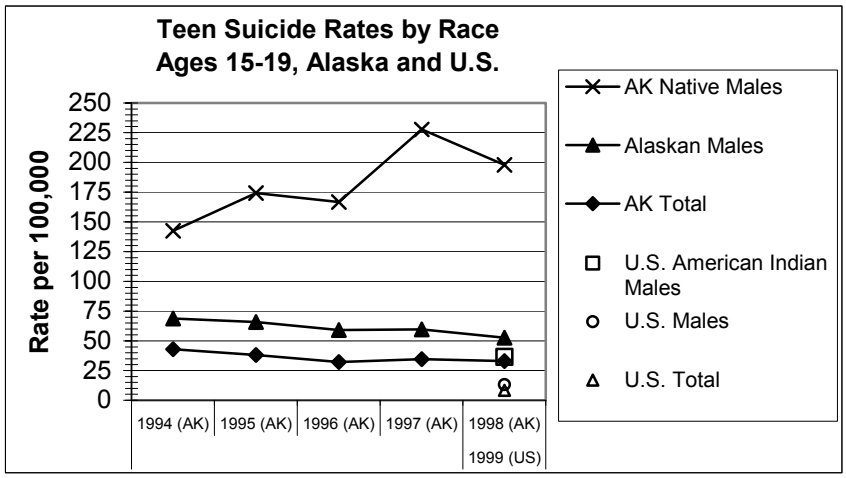
Rural Human Services Expansion – Rural Substance Abuse Counselors - $867.7 GF/MH
Rural Human Service workers provide assessment and referral services at the local level for individuals needing care provided through hub communities. In addition, they provide continued support and aftercare to individuals who return to their community.

The program has proven to be successful because it provides the opportunity for local residents to combine their cultural knowledge with alcohol and mental health counseling and intervention skills.

Fourteen sub-regional or regional organizations currently participate in the Rural Human Services program through grants from the Division of Alcohol and Drug Abuse. Several regions of the state still lack services and not all regions with Rural Service grants are able to serve all the communities within their region. This additional funding will provide salaries, training and supervision, clinical space, supplies and support for 18 additional workers.

Suicide Prevention Grants - $500.0 GF
Alaska leads the nation in suicides. The suicide rate for Alaskans of all ages is 23.7 per 100,000 population, about twice the U.S. rate of 10.3.

Even more alarming is the suicide rate of male Alaska Native teens, which for the period 1997-1999 was 197.5 per 100,000. That was 5.4 times that of the group with the highest suicide rate reported nationally in 1999 (male American Indian teens). The suicide rate of male Alaska Native teens rose by 38.8% from 1993-1995 to 1997-1999.



The overall teen suicide rate declined in Alaska by over 23%, from a three-year average of 43.1 per 100,000 in 1993-1995 to 33.0 per 100,000 in 1997-1999. Nevertheless, overall teen suicide continues to be a major concern in Alaska, being nearly four times the U.S. rate of 9.5 per 100,000

The division will work with the Alaska Suicide Prevention Council, which was created by the Legislature in FY01-02, to determine the best way to implement expanded suicide prevention programs. It is anticipated that this increment will allow the division to move from a rural focus to a statewide focus adding additional programs in the urban areas as well. It could also allow grants to local providers to fund the addition of 25 to 35 counselors for this expansion and make available more training for the grantees in intervention, identification and referral.

Miscellaneous Transfers
Starting with the FY2002 Management Plan and continuing with the FY2003 budget process, the Division of Alcoholism and Drug Abuse is reorganizing their structure to better reflect the work that the division does, and to give responsibility and accountability to the program managers. This reorganization resulted in new components being created and old ones being deleted, and in an abnormal number of transfers taking place between the components.

Division of Mental Health & Developmental Disabilities

Mission

To improve and enhance the quality of life for consumers impacted by mental disorders or developmental disabilities.

Introduction

Towards that end, the Division of Mental Health and Developmental Disabilities administers a broad array of supports and services to eligible Alaskans and their families. Our programs are grouped into four major Division sections:

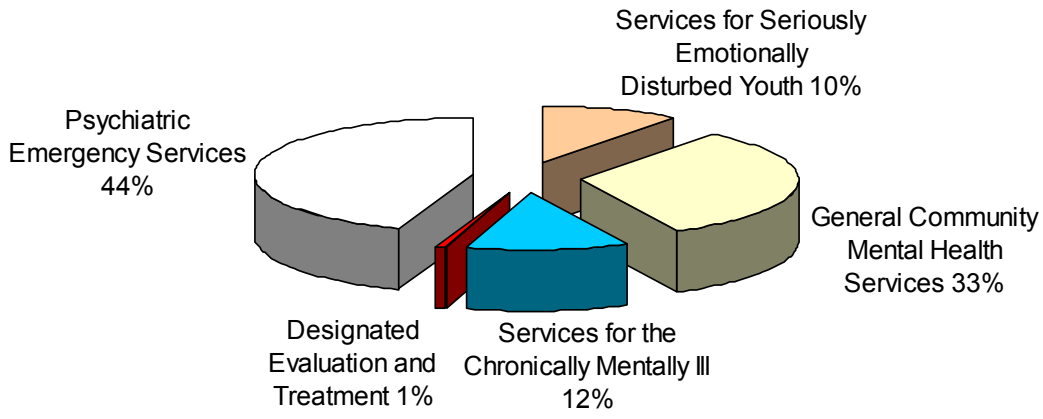
- Community Mental Health
- Community Developmental Disabilities
- Safety & Quality Assurance
- Alaska Psychiatric Institute

The Division collaborates with the Alaska Mental Health Trust Authority (AMHTA), the Governor's Council on Disabilities and Special Education (GCDSE), and the Alaska Mental Health Board (AMHB) to implement projects that protect and promote the well being of Alaskans with mental illness, a developmental disability, or both. With a strong emphasis on community services, the Division's service systems enable consumers to lead more productive lives in their own homes, surrounded by family and friends.

Community Mental Health Program

- Administered $70.1 million funding support to community mental health centers statewide, of which 57% was covered by Medicaid receipts and 43% was allocated through DMHDD state grants.
- Served over 20,000 mental health consumers through Medicaid and Community Mental Health grants.
- Administered grants through 47 grantees, including 15 grantees serving 131 youth through the Alaska Youth Initiative program.

Consumers Served Through Community Mental Health Programs



Community Developmental Disabilities Program

- Administered $67.9 million funding support for individuals served through community developmental disability providers statewide, of which 71% was covered by Medicaid receipts and 29% was allocated through DMHDD state grants.

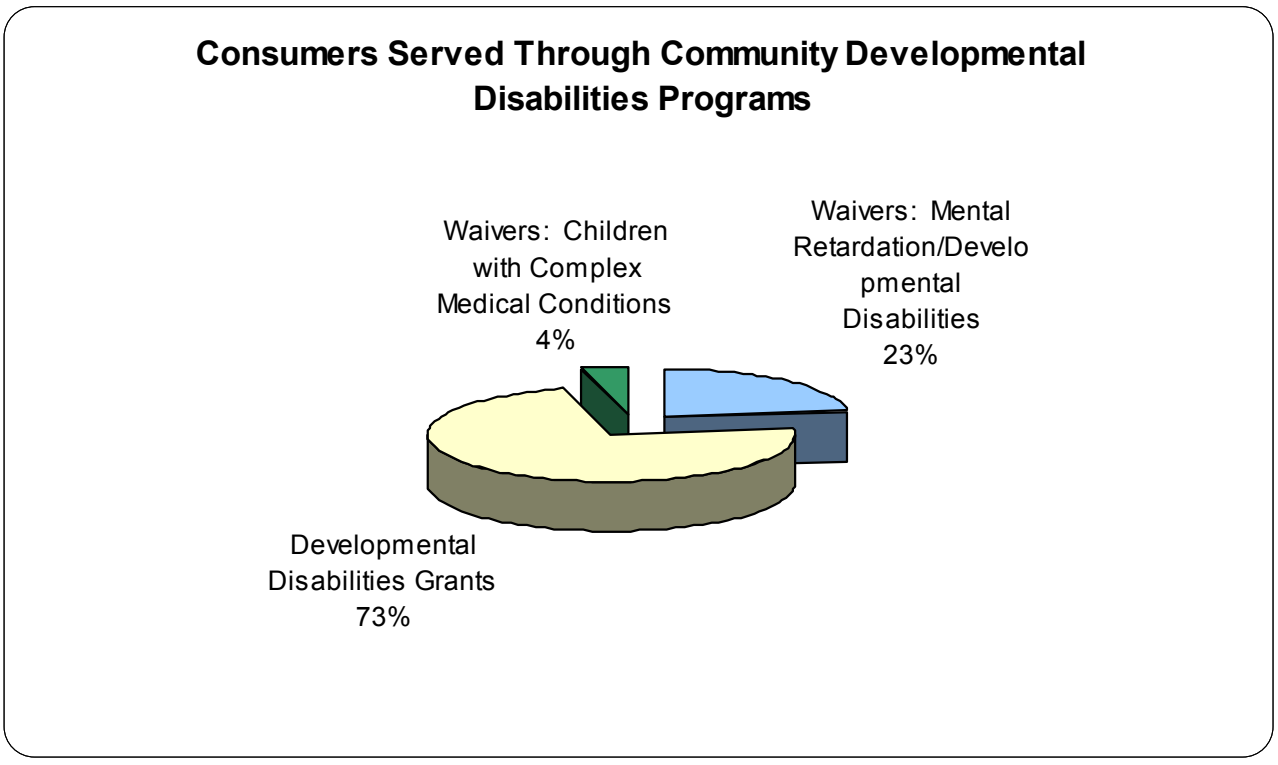
- Served 2,460 developmental disabilities consumers in 150 communities through Community Developmental Disabilities grants to 30 agencies in FY01.

- Served 143 consumers in 21 communities through Children with Complex Medical Conditions (CCMC) Medicaid waiver services.

- Served 779 consumers in over 100 communities through Mental Retardation/Developmental Disabilities (MRDD) Medicaid waiver services.

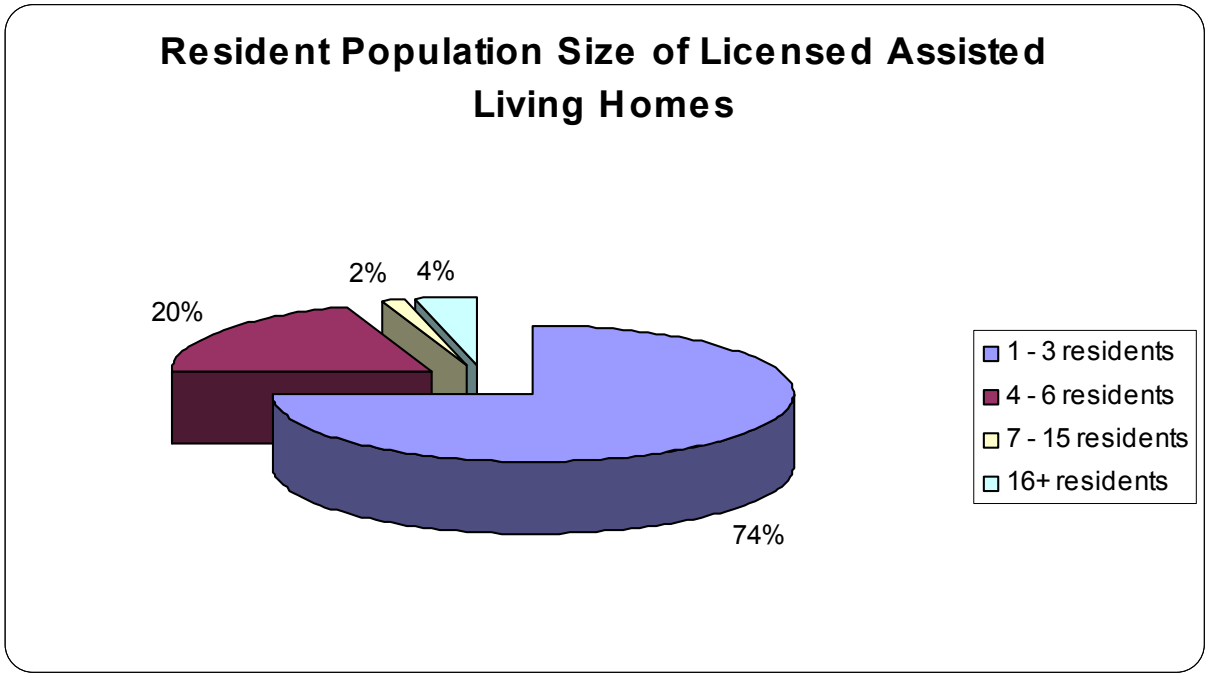
- Offered Core Services to over 430 consumers on the Waitlist receiving no other services.

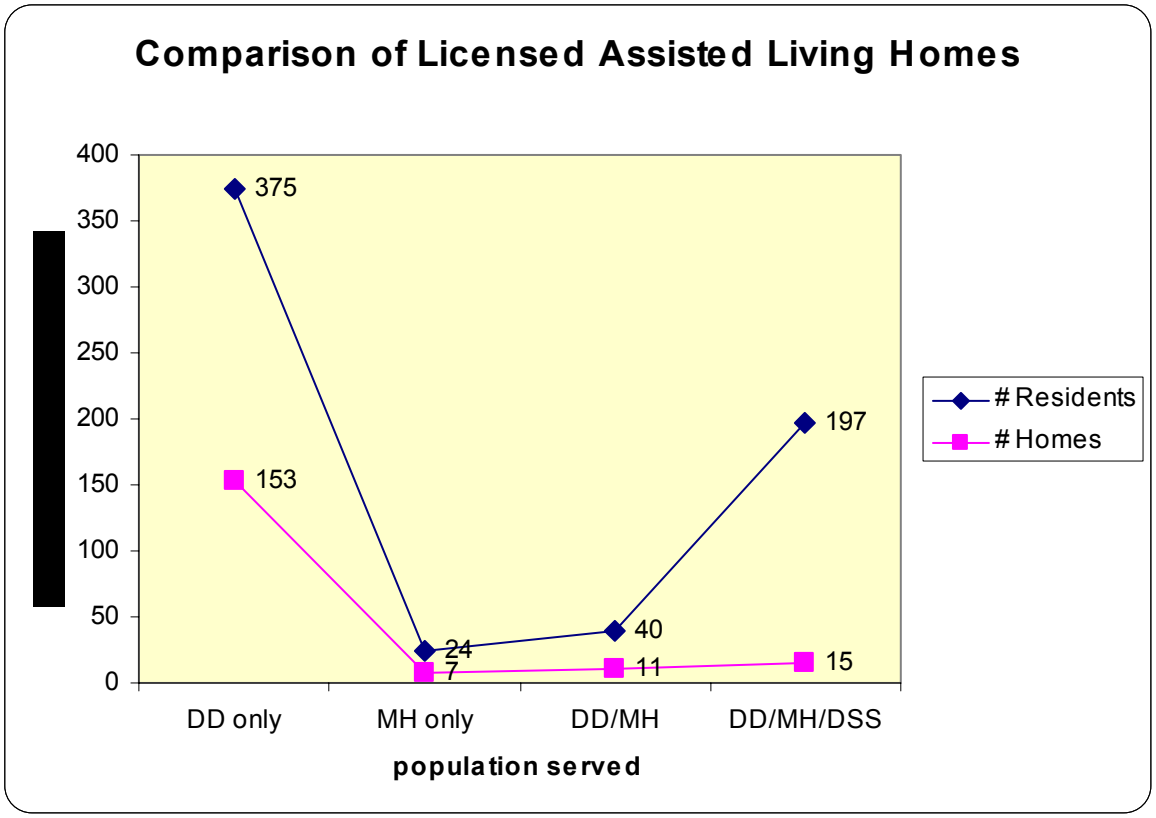
- Selected 259 consumers for more comprehensive long-term care in FY01.



Safety & Quality Assurance

- Licensed 186 Assisted Living Homes serving 636 residents.
- Conducted 261 on-site visits to Assisted Living Home facilities.
- Conducted integrated quality assurance reviews for 12 agencies (Mental Health/Developmental Disabilities/Infant Learning Program) in FY01.
- By provider, compliance rates ranged from 26% to 98%, generally higher in urban regions than in rural regions.
- Provided 334 direct clinical training hours, not including consultations by telephone or e-mail.
- Conducted approximately 60 trainings to assist mental health grantees with the transition to new Medicaid regulations.



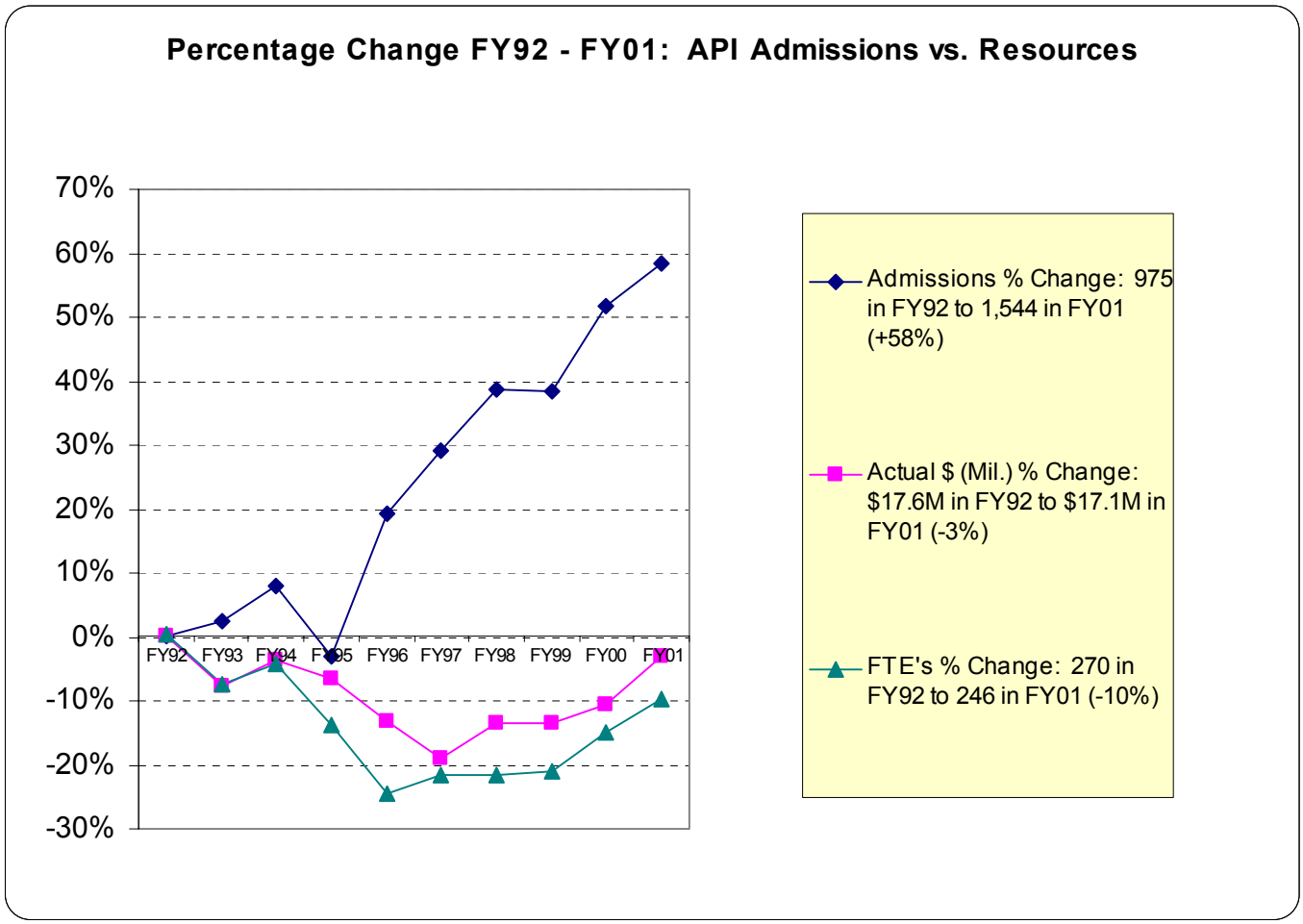


Integrated Quality Assurance Reviews Performed in FY01

Agency	*Location*	*Date Reviewed*
ACCESS Alaska	Fairbanks	May-01
Bristol Bay Mental Health Center	Dillingham	Jan-01
Center for Community	Sitka	Dec-00
Central Peninsula Counseling Services	Kenai	Sep-00
Cordova Community Hospital	Cordova	Nov-00
Frontier	Kenai	Jan-01
Homer Infant Learning	Homer	May-01
Hope Community Resources	Dillingham	Apr-01
Island Counseling Center	Sitka	Oct-00
Kenai Community Care Center	Kenai	Sep-00
Kodiak Area Native Association	Kodiak	Feb-01
Kuskokwim Native Association Community Counseling	Aniak	Sep-00

Alaska Psychiatric Institute

- 1,544 persons admitted in FY01 (an increase of 63% since FY95).
- Average daily census in FY01 was 66 patients.
- Average length of stay (ALOS) for a patient at API in FY01 was 10 days (excluding those few patients whose stays at API exceeded 180 days; the ALOS in FY01 for *all* patients was 19 days).



List of Primary Programs and Statutory Responsibilities

The Division of Mental Health and Developmental Disabilities (DMHDD) is the agency responsible for implementation of State laws that protect and promote the well being of Alaskans who experience mental illness or developmental disabilities. DMHDD is governed primarily by two Alaska Statutes:

AS 47.30, Mental Health
AS 47.80, Persons with Handicaps.

Through its community mental health and community developmental disabilities programs, DMHDD provides support and a wide range of community-based services throughout the state to individuals who experience mental illness or developmental disabilities. Support services are provided primarily through grants awarded to local community providers. Consumer, family and provider participation is emphasized in determining the path for each individual's services.

DMHDD also operates Alaska Psychiatric Institute (API), the state's only public mental health hospital. Located in Anchorage, API provides psychiatric inpatient care to those individuals whose service needs are beyond the capacity of local community mental health providers.

Community Mental Health Program
Alaska's Community Mental Health Program provides an array of community-based outpatient, residential, and locally provided inpatient mental health services for five specific priority populations.

Psychiatric Emergency Service
Provides aid to adults and youth in psychiatric crisis. Services include crisis intervention, respite and brief therapeutic intervention to help stabilize the client.

Designated Evaluation and Treatment
*S*erves people under court-ordered psychiatric commitment. On a "payer of last resort" basis, funds psychiatric evaluation and treatment services at local hospitals, physician services and client/client escort travel between home and hospital. As a hospital alternative, also funds enhanced detox services for persons intoxicated and expressing suicidal ideation.

Services for Seriously Emotionally Disturbed Youth
*S*erves youth who are seriously emotionally disturbed or at high risk of becoming so, and their families. Support services include evaluation and diagnosis, treatment planning, case management, life skills training, medication management, residential treatment options, psychosocial rehabilitation and educational supports. Also funds the Alaska Youth Initiative (AYI) program, which provides fee-for-service, individualized "wrap-around" services for youth who are the most severely disturbed and at risk for out-of-state placement.

Services for the Chronically Mentally Il
*S*erves adults with severe and persistent mental illnesses. Support services include evaluation and diagnosis, treatment planning, case management, life skills training, medication management, psychiatric and nursing services, vocational skills training, residential treatment options, psychosocial rehabilitation and educational supports.

General Community Mental Health Grants
*S*erves people experiencing depression, suicidal ideation or behavior, or other serious but generally not persistent or disabling psychiatric disorders. Funds local community mental health programs for individuals and families.

Community Developmental Disabilities Program
Alaska's Community Developmental Disabilities Program administers statewide community-based services for people who experience developmental disabilities. Services include:

Care coordinators
To help consumers gain access to needed services including screening, assessment, and care plan development and implementation.

Chore services
For assistance necessary to maintain a consumer's home in a clean, sanitary and safe condition, and necessary to avoid placing the consumer in an out-of-home or institutional setting.

Environmental modifications
For physical adaptations to a consumer's home, identified in a consumer's plan of care and necessary to insure health, welfare, and safety.

Residential habilitation services
To help consumers acquire, retain and improve self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings of their choice. Training takes place during normal daily routines and is designed to enhance functional life skills.

Respite care
To provide relief from the everyday stress of caring for a family member with a developmental disability, and which may forestall or prevent out-of-home placement.

Specialized adaptive equipment and supplies
To increase the consumer's abilities to perform daily living activities.

Job training
To assist in attaining the skills necessary to become employed. Employment may be in the community, sheltered workshops, or subsistence.

Safety & Quality Assurance
The Safety & Quality Assurance section of the Division is a recent consolidation of efforts related to safety and quality care, and includes the following functions: quality assurance (both inpatient and outpatient), assisted living (including licensing, monitoring and investigations), statewide training coordination, and utilization review for the Community Mental Health/API Replacement Project.

At present, the majority of DMHDD grantees are on a two-year integrated quality assurance review cycle. These reviews are a valuable tool for directing further training efforts, focusing future quality assurance reviews and ensuring that the community-based service delivery system meets consumers' needs.

The Assisted Living Home Program promotes the establishment of residences that provide an affordable home-like environment where adults with a physical or mental disability--and in need of help with daily living activities--can receive assistance to become integrated into the community and reach their highest level of functioning. The program also identifies services that meet residents' reasonable wants and needs, and provides them the opportunity to participate to the fullest extent possible in the design and implementation of these services. To protect and reduce risk to assisted living home residents and ensure that statutory and regulatory safety standards are met, DMHDD conducts annual monitoring of licensed homes that provide residential alternatives to nursing home placement.

Alaska Psychiatric Institute
Alaska Psychiatric Institute is a 74-bed hospital that provides seven day a week, twenty-four hour inpatient care and treatment for Alaskans with severe and persistent psychiatric disorders or serious maladaptive behaviors.

API serves adults and adolescents whose need for short-term, acute psychiatric services exceed the capacity of local community mental health service providers. API also provides longer-term care for organic or highly complex and difficult to place patients. Finally, API provides court-ordered competency evaluations of persons accused of crimes, and treatment for patients found incompetent to stand trial or not guilty by reason of insanity.

Clients from all regions of the state are admitted to API voluntarily, or admitted involuntarily through either a Peace Officer Application or an Ex Parte Commitment from a judge or magistrate, physician, mental health professional, or community mental health center. Approximately 85% of API's clients are indigent, with no third party payment resources.

Services provided at API include

- screening and referral
- medication stabilization
- psychosocial rehabilitation services
- multidisciplinary assessments
- individualized and group therapy and counseling
- patient and family education
- inpatient psychiatric treatment with an increasing focus on the role recovery approach

Special effort is made to involve family members in treatment and to transition patients with serious, persistent or chronic mental illness into community settings. API also provides outreach, consultation, and training to mental health service providers, community mental health centers, and nursing, social work, psychology, rehab, and medical student interns. API is also expanding into telepsychiatry services.

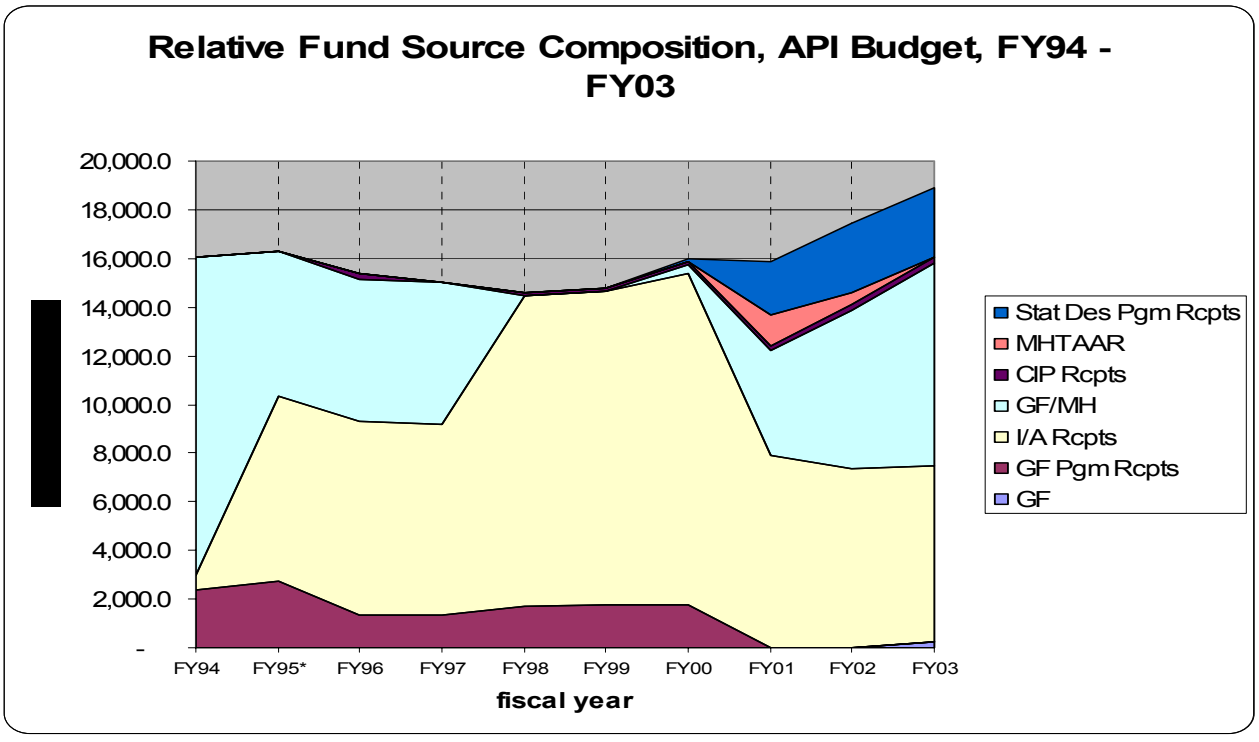
API Fund Source Change

The Balanced Budget Act of 1997 capped the total amount of federal Medicaid "Disproportionate Share Hospital" (DSH) program funding available to hospitals serving a preponderance of indigent people. The Act also imposed a three-year incremental decrease in the proportion of DSH available for mental institutions vs. other types of hospitals. As a result, by federal FY03 API will have lost over $8.0 million in annual DSH revenues. To help replace those funds, the Division and the Trust developed a plan for two years of alternate funding for API, which ends in FY02. The Trust's intent was to allow the State time to phase in increasing GF/MH support of API, to make up for the dwindling DSH funding. For FY03 API seeks a $1,249.2 GF/MH increment to largely offset the FY03 loss of <$877.5> DSH I/A and <$491.5> MHTAAR.

Simultaneous to these DSH changes, API has seen an increase in the utilization of their Chilkat youth treatment and rehabilitation unit. Services for many of these patients are Medicaid-reimbursable, and API's related revenues from direct billings have grown considerably. The Division seeks a $700.0 I/A expenditure authorization increment in order to tap these revenues.

The net effect of these four transactions is a $580.2 increment. API's costs of operation continue to escalate, driven by such factors as:

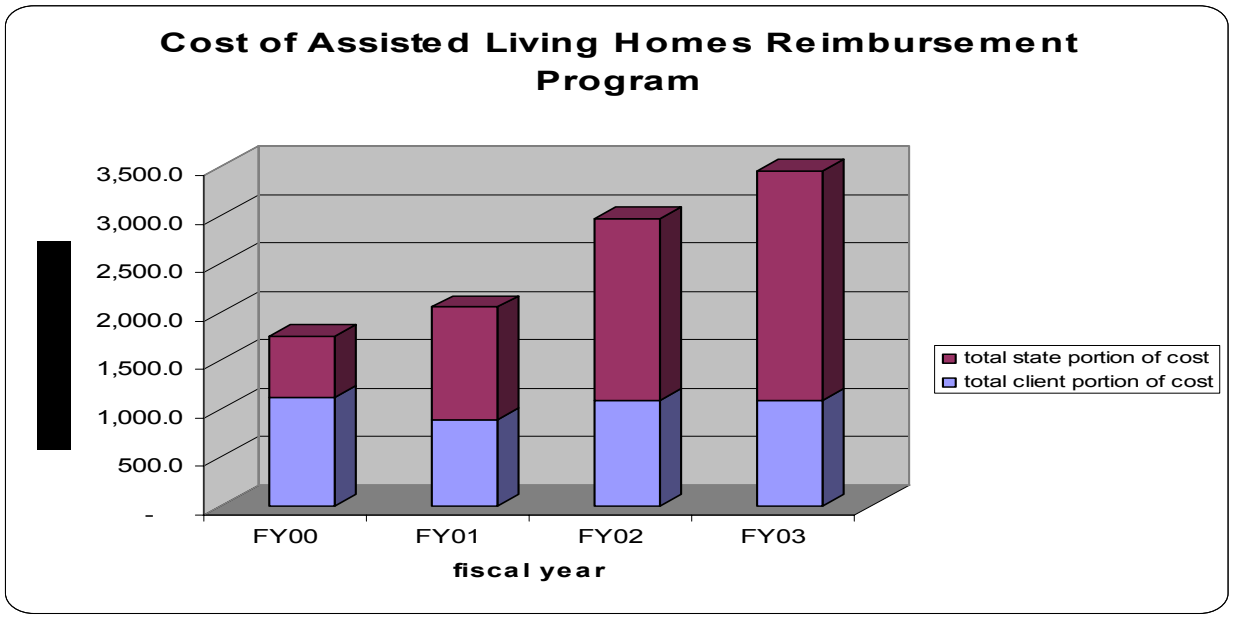
- the increasing severity of the population served
- an estimated 20% increase in the cost of pharmaceuticals
- patient & escort travel costs in excess of the API budget for the last several years
- the escalating costs for API's annual medical, dental and locum tenens contracts



Safety and Quality Assurance
This $360.5 GF/MH increment request will allow the Division to consolidate and expand its efforts related to safety and quality care by implementing a new Safety & Quality Assurance unit. Its functions will include quality assurance (both inpatient and outpatient), assisted living (including licensing, monitoring and investigations), statewide training coordination, and utilization review for the Community Mental Health/API Replacement Project.

Demands on the Division for licensing assisted living homes, monitoring MH and DD service provision, and providing technical assistance to provider agencies continue to escalate. Without additional resources, the Division's ability to meet legal requirements to ensure the safety of our consumers is threatened. The number of assisted living homes under our authority has increased in the last 11 months from 143 to 184 homes, and is expected to soon be well over 200. Similarly, there are increasing demands on our quality assurance staff to maintain their current review efforts with mental health grantees, and increase monitoring of developmental disabilities providers and inpatient mental health facilities.

Assisted Living Home Rate Increase
Senate Bill 73, implemented in FY01, called for a three-year phased increase to the daily reimbursement rate for assisted living home care for consumers impacted by mental disorders or developmental disabilities. FY03 marks the final phase with a reimbursement rate increase from $60 to $70 per day, per eligible resident. This funding provides services for approximately 130 adults on General Relief through the assisted living homes currently monitored and licensed through DMHDD.



Operators of these homes are concerned about the inadequacy of the reimbursement. Despite the FY01 and FY02 rate increases already implemented, the reimbursement rate continues to be less than that offered through individualized services funded by a combination of developmental disability waivers, consumer entitlements, or private pay. The cost of care itself continues to escalate through inflation and the rising federal minimum wage, and as the population served becomes more significantly impaired and progressively more difficult to manage. These assisted living homes are a vital part of the array of community services and offer a viable alternative to hospitalization at Alaska Psychiatric Institute (API), nursing home placements, and homelessness.

This transaction combines a <$459.0> MHTAAR decrement, as Trust funding is phased out, and a $952.8 GF/MH increment to complete the three-year plan.

Enhanced Crisis Respite Fund Source Change
Enhanced Crisis Respite Care is offered to adults experiencing acute psychiatric crisis, who may be psychotic or have a potential for violence, but whose symptomology is not severe enough to warrant either placement in a secured facility or hospitalization. This program is frequently used as a transitional or lower intensity, less restrictive service for consumers as they leave API. The expected length of stay of a crisis respite patient is 4 to 6 days with an extension of up to 7 days depending upon the patient's condition. Crisis respite care saves the state the cost of unnecessary and expensive hospitalizations and shortens hospital stays. The Division requests a $495.6 GF/MH increment, or approximately half the cost of this project, and the federal authorization it replaces is being transferred out of the component.

Developmental Disabilities Program Infrastructure
FY03 will be the fourth of a 4-year agreement between the Trust and legislature to preserve the infrastructure of developmental disability service providers, and represents the final fund source change of $120.0 from MHTAAR to GF/MH. As of FY03 the project's full $964.8 funding will be GF/MH incorporated into the DD program's base budget. Project funds are being used to: increase salary levels and benefits to both retain and attract qualified staff; ensure that employees receive adequate training to provide quality services; and ensure that programs meet or exceed the program standards established by the Department of Health and Social Services. Until FY00, all new funds in the DD program were allocated toward serving people on the wait list, with no increases allocated for the basic provider infrastructure in many years. Staff turnover is high and many DD providers have difficulty recruiting qualified staff. Wages are still not competitive with comparable occupations in the state.

This struggle to both attract and retain qualified staff affects not only the quality of services provided, but also the basic health and safety of individuals with developmental disabilities. Without adequate, qualified staff, many consumers will be at risk of placement in nursing homes, hospitals, jails, Alaska Psychiatric Institute, or out of state. All of these alternate options are a far greater cost to the State than current efforts to support the existing community infrastructure.

Mental Health Information System
The Division has laid plans for both short-term and longer-term solutions to address the dearth of mental health data reporting. For years the Division struggled with connectivity and data submission issues tangled around the mental health ARORA database. Staff and provider agencies agreed that all would benefit from the Division's ability to report on services being delivered, the type of accountability the legislature and others have been requesting of us for years.

As of FY02, we implemented the short-term plan of limiting the numbers of required mental health data fields, urging more providers to submit demographic and service data on paper if electrical transmission was flawed, and holding providers accountable for regular monthly submission by tying grant advances to our receipt of their data. As a result, data submission compliance has jumped dramatically. This winter the Division will begin producing preliminary reports from aggregate data, and more detailed reporting will become available thereafter.

Concurrent with this stopgap process, we have been planning for longer-term mental health reporting solutions that would also address the issues of data integration with the Medicaid system as well as the Division of Alcohol & Drug Abuse (ADA), since many provider agencies serve both MH and ADA consumers. Through funding available from several sources, Information Systems staff from both divisions anticipate conducting a needs assessment during FY02 and launching into the planning, design and development of a web-based front-end application which would both resolve provider connectivity issues and address the divisions' needs for system integration.

Being able to accurately report on the volume, cost, recipients and outcomes of services will strengthen the credibility of the Community Mental Health program, as the Division and individual providers seek financial support from State and federal sources.

In FY03 this project will be supported by a $100.0 federal increment and a $500.0 federal transfer from the Community Mental Health, Psychiatric Emergency Services component.

Developmental Disabilities Grantee Support & Training
The Developmental Disabilities program has been undergoing a dramatic transformation with the advent of Medicaid waivers for people with mental retardation and children with chronic medical conditions. Significant formalization and changes are becoming necessary in areas such as eligibility determination, care coordination, plan of care development and client database development. The regulatory and policy framework regarding DD services will need to be modified to reflect these program changes. Finally, an intensive long-term training effort will be necessary to train DD staff, provider agencies, families and advocates regarding these comprehensive system changes. The Division requests a related $250.0 I/A increment.

Division of Administrative Services

Mission

To provide quality administrative services that support the Department's programs.

Introduction

The Division of Administrative Services is one of eight divisions within the Department of Health & Social Services. The Division of Administrative Services is responsible for providing a full range of support services to the department. These include, but are not limited to accounting, human resources, payroll, budgeting, procurement, information systems support, grants administration, audit, planning, facilities acquisition and management, and support for the Designated BRUs and the Mental Health Trust Boards. The Division of Administrative Services consists of the following components:

- Commissioner's Office
- Personnel and Payroll
- Administrative Support Services
- Health Planning & Facilities Management
- Audit Section

Primary Programs and Statutory Responsibilities

AS 37.10: Financial Management
Statutory responsibilities include sound fiscal management and revenue collection of state, federal, and other funds.

AS 37.07: Budget Section
Responsibilities include the coordination, preparation, analysis, and implementation of the operating budget.

AS 36.30 Procurement Section
The Procurement Section provides technical and support services associated with the procurement of goods, services, and office space in accordance with applicable statutory and regulatory requirements.

AS 37.07.062 Capital Projects
The Health Planning & Facilities Management section is responsible for preparation, submission, and competent management of annual capital budget requests and projects.

AS 39.25: Personnel & Payroll Section
The Personnel & Payroll Section is responsible for personnel management functions and payroll processing for the Department's 2,500 employees.

The following are the Legislative Performance Measures for Administrative Services
:

Cost of Administrative Services Personnel versus cost of Department Personnel.
In FY2001, Administrative Services personnel cost was 4.34% of the Department total.

Percentage of Grievance/Complaints Resolved without arbitration.
In FY2001, 97% of all grievances/complaints were resolved without arbitration.

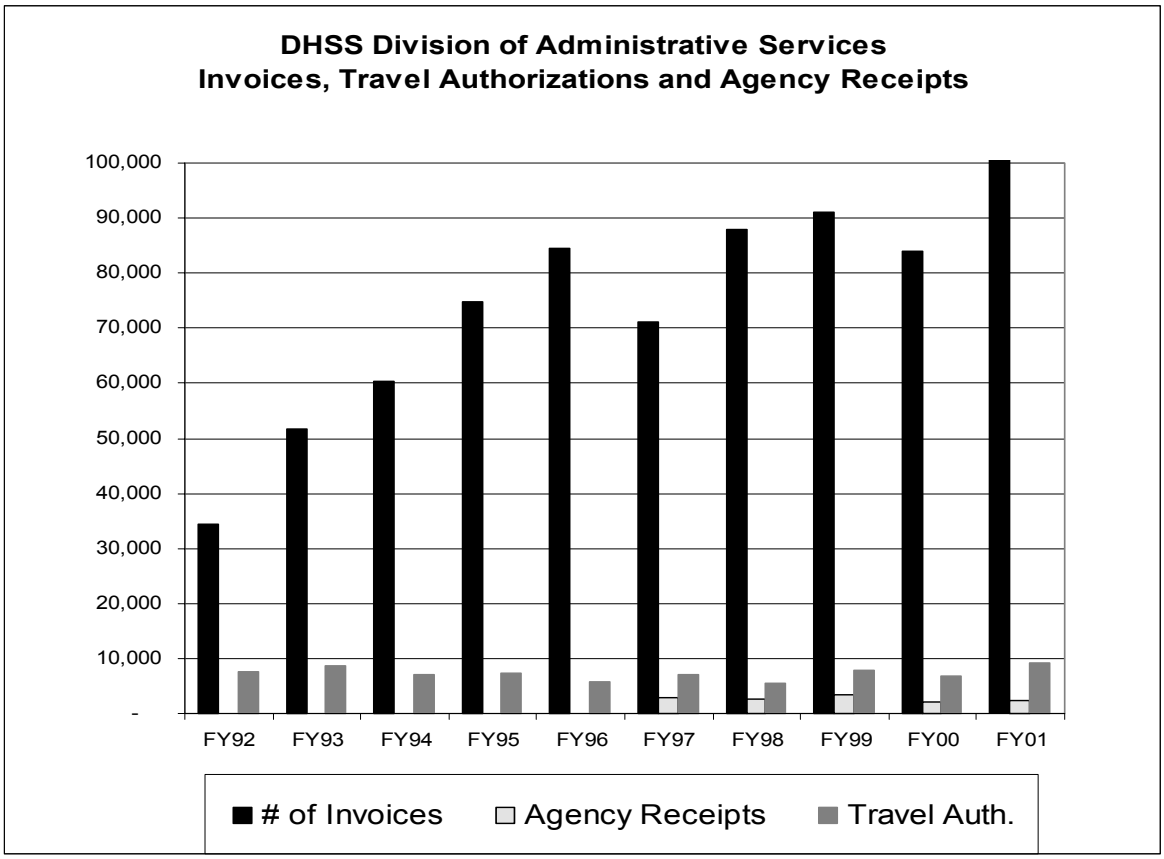
Average number of days for Vendor Payments.
In FY2001, the average number of days was 33.

Percentage of Audit Exceptions that are resolved.
In FY2000, there were 6 audit exceptions, 100% of which will be resolved by 6/30/2002.

Finance Section
The Finance Section within the Division of Administrative Services supports eight divisions within Health & Social Services. It is responsible for financial accounting, federal reporting and related support services. The following chart reflects Finance Section Activity from FY92 to FY01:

Key FY 2003 Performance Measure: In FY2001, there were 95,064 payments made and 2,424 agency receipt transactions processed. Average processing time from date of invoice was 33 days.

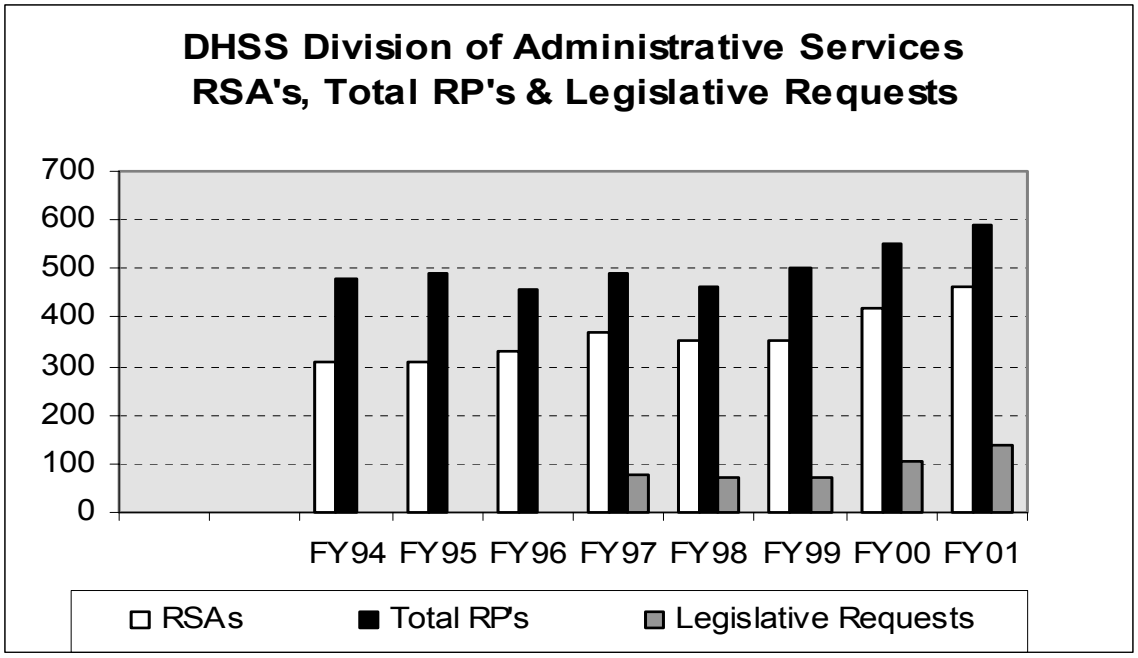
It is notable that the number of invoices increased 13% between FY00 and FY01, an increase of over 10,000 invoices. An increase of this magnitude is difficult to absorb, which is why we are requesting non-general funds to increase key staff in the Finance section.



Budget Section
The Budget is responsible for analyzing, monitoring, and controlling the Department's annual operating budget, budget amendments, revised programs, supplemental budgets, fiscal notes and legislative requests for information. The following chart reflects Budget Section activity:

Key FY 2003 Performance Measure: Anticipate processing 85% of Revised Programs within 3 workdays. In FY2001, there were 589 Revised Programs logged. Out of those, eighty percent or 469 processed within 3 workdays.

Total Revised Programs had been averaging close to 500 for the last several years. Between FY99 and FY2001 the number of revised programs grew by 89 or almost 18%. The only explanation for this type of growth is the overall growth in the DHSS budget between FY99 and FY01 (increase of 17%). Although the budget grew in the years preceding FY99, it is unclear why Revised Program activity stayed flat over that time period and only shot up the last few years. The increase in activity has been absorbed with existing staff, but if growth continues at this rate, workloads will have to be reevaluated.

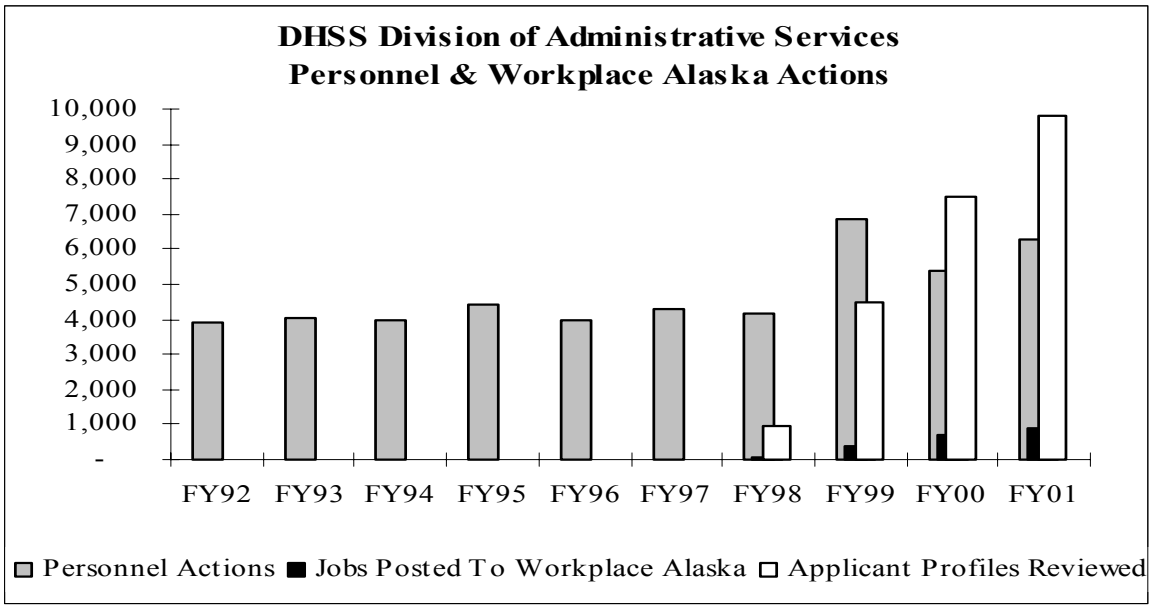


Personnel and Payroll Section
The Personnel and Payroll Section is responsible for personnel management within the Department. The section serves about 2,500 employees located in more than 50 geographic locations. The following chart reflects activity for the Personnel and Payroll Section:

Key FY 2003 Performance Measure: Anticipate 94% of Personnel Actions processed within 15 workdays. In FY2001, 6,309 Personnel Actions were processed.

It is clear that the massive increase in Workplace Alaska activity has impacted Department Human Resource offices. In particular, job orders increased from 233 in FY99 to 750 in FY01. That means that in FY01 DHSS attempted to hire 750 people, which is over 30% of the workforce! Workplace Alaska, while more flexible than the old "register system", requires much more work from personnel staff and hiring managers. For example personnel staff review questions, approve posting of jobs, advise managers on all types of hiring issues, determine legal hires prior to job offers being made, etc. None of these work activities existed prior to the implementation of Workplace Alaska.

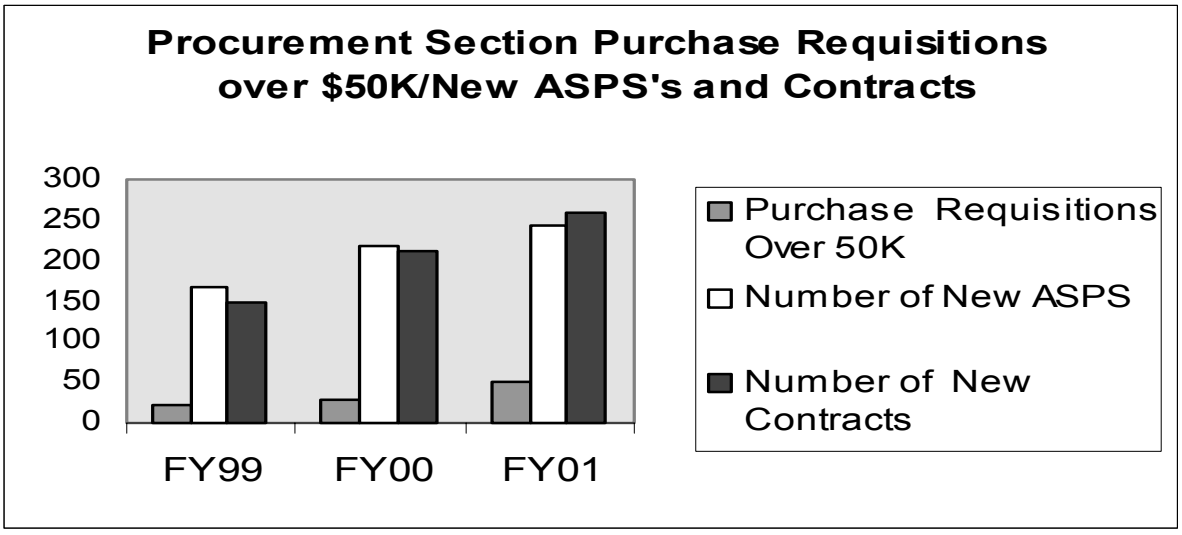
Recruitment and retention issues in all sectors of the DHSS workforce led the department to contract for development of a Workforce Development plan. The plan should be finalized by March 2002 and will provide DHSS with a 5-year plan of steps to take to make sure that sufficient staff will be available to complete the missions and goals of all divisions within the Department.



Procurement Section
The Procurement Section is responsible for procurement, property control and leasing for the Department. The following is Procurement Activity.

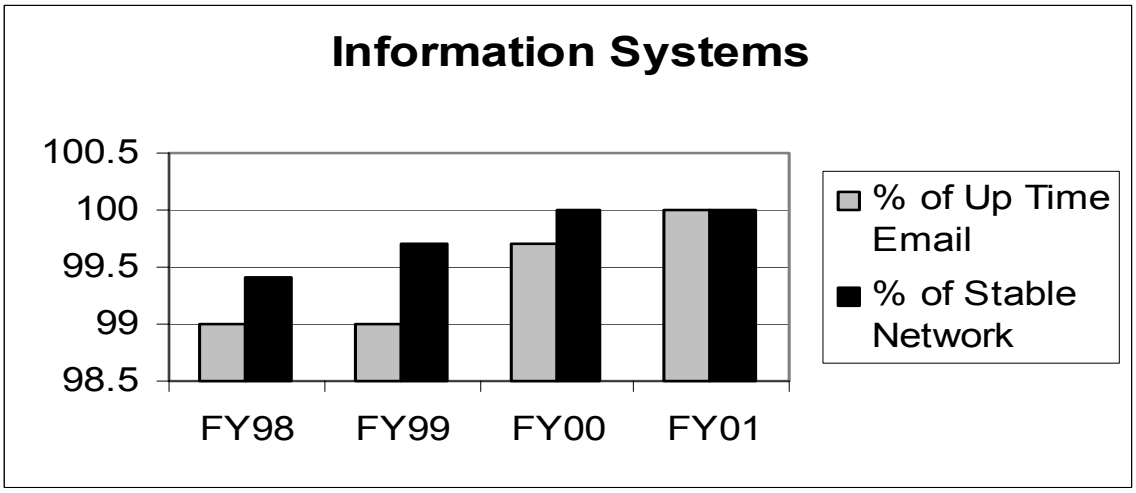
Key FY2003 Performance Measure: Anticipate turnaround time for processing Purchase Requisitions (PR's) over $50,000 within average of 25 work-days. Status: In FY2001, average length of time to process PR's over $50K was 23 days.

Purchase Requisitions (PRs) received that are greater than $50,000 generally are complex in nature and require specification research and formal bidding procedures. This area of work has doubled since FY99, requiring DHSS Procurement staff to spend more time and perform more complex duties. Professional Service Contracts for DHSS have increased by 50% since FY99. These are often multi-million dollar contracts, covering a variety of services ranging from tobacco cessation education to psychiatric services. Procuring and managing professional service contracts is extremely difficult and time consuming and often requires extensive knowledge of DHSS programs and policies.



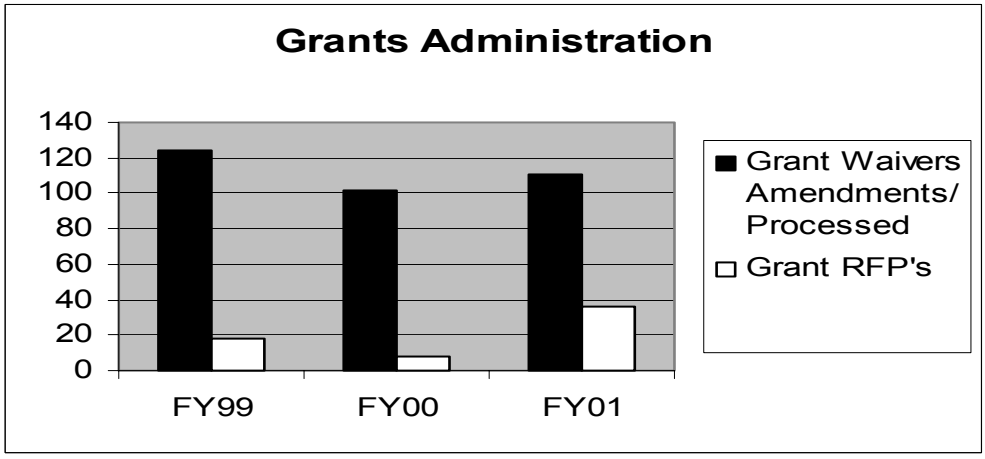
Information Systems Section
Information Systems provides the computing and network infrastructure for DAS users, interfaces with other State organizational units, and represents the Department in information systems matters involving other organizations.

Key FY 2003 Performance Measure: Anticipate network up and running 100% of the time. Status: In FY2001, network was up and running 8,752.1 hours or 99.9% of the time.



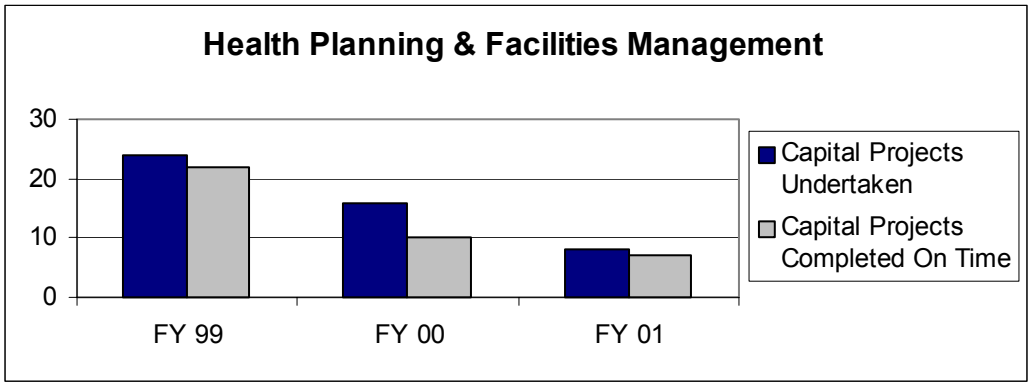
Grants Administration Section
Grants Administration Section is responsible for coordination and standardization of grant processes, as well as providing assistance and training for staff in the procurement and administration of grants for the department. DHSS has approximately 655 grants totaling over $115 million.

Key FY 2003 Performance Measure: Anticipate processing 95% of all grant waivers and amendments within 3 workdays. Status: In FY2001, we received 111 requests from 289 grantees. 93% of grant waivers and recommendations were processed within 5 work days and 7% within 7 work days.



Health Planning and Facilities Management Section
The Health Planning and Facilities Management Section is responsible for research, planning, and oversight of capital projects for the department. This includes managing all renovation and repair, deferred maintenance, and major capital construction projects. The Department operates 35 state-owned buildings throughout Alaska, at a replacement value of $224.3 million.

Key FY 2003 Performance Measure: Anticipate 92% of capital projects completed on time and within budget. In FY2001, 8 capital projects were scheduled to be completed, of which 7 were completed on time and within budget.



Explanation of FY2003 Budget Changes

All budget changes within the Administrative Services Division are non-general fund adjustments. A short description of the changes follows:

Personnel and Payroll Component
In the past several years the Department of Health and Social Services has added a number of positions including: staff to open more juvenile youth facilities, social workers, public health nurses, and federally funded positions. This increase in the number of direct service staff has severely impacted personnel and payroll staff, since there are more employees to provide service to. Also, implementation of Workplace Alaska and additional delegations from Department of Administration, Division of Personnel, has resulted in the need to increase our staffing.

One measure of the need for more staff is the comparison of the number employees in each department to the number of Human Resource staff. The ratio varies by Department from 67 employees per HR staff person to 128, with 10 of 13 departments having a ratio of less than 110, and with the average being 94. The DHSS ratio was 117 employees for each Human Resource staff person. We think this rate is too high to consistently do a credible and timely job of processing all of the personnel and payroll work that needs to be accomplished. The additional resources included in this request will bring the ratio down to 103 employees for each HR staff person, a more reasonable level.

Additional federal and interagency receipt authority is requested to allow Human Resources to continue providing support to the divisions within the department. The additional federal funds will be generated from the DHSS and statewide cost allocation plans.

Administrative Support Services Component
This increase in federal authority will be used to continue service levels to department divisions, to pay for increased costs in personal services, fund one position created in FY2002, and pay for additional costs associated with core service chargeback. The additional federal authorization will be used to receive funds generated by the Statewide Federal Cost Allocation Plan to directly offset the increased statewide costs being charged to the department.

Facilities Rent Pilot Project
For FY2003, the rates have increased for all buildings within the rental pool. This increment of federal authority will be used to offset the increased cost of the facilities that H&SS occupies in FY2003. These funds are designed to improve the condition of state buildings and prevent additional deferred maintenance problems. This program will recover federal funds from appropriate DHSS federal programs to allow additional investment in maintenance, renewal and replacement for the building pool.

Mental Health Trust Boards

Mission

To act as the state planning, monitoring, advocacy and coordinating agencies for persons experiencing mental illness and serious emotional disorders, substance abuse disorders, developmental disabilities, students in special education and infants and toddlers with disabilities.

This BRU was established in FY96 and is comprised of the Advisory Board on Alcoholism and Drug Abuse, the Alaska Mental Health Board, and the Governor's Council on Disabilities and Special Education. All three boards have experienced prior budget reductions while coping with additional costs and requirements of the Mental Health Trust Settlement including additional travel by representatives of the Boards. To assure coordination among the Boards and maintain effective relationships with the Trust Authority and the Department, the Boards must participate in planning meetings with the Department and make regular presentations at the meetings of the Trust Authority.

Under the law, the Governor's Council has increased duties and responsibilities. Federal funds used to operate the Council are being reduced and are inadequate to meet the requirements of the state law. Additionally, the costs associated with participating in Trust activities may not be allowable under the provisions of the federal grant.

The Alaska Mental Health Board has additional duties as a result of the Trust settlement legislation. These are primarily related to the Comprehensive Mental Health Plan and Trust Authority activities. In addition, board membership was expanded under the law, directly affecting the adequacy of travel funding.

Primary Programs and Statutory Responsibilities

AS 47.80.090 (1-13) Governor's Council on Disabilities and Special Education
The Council is responsible for interdepartmental planning and coordination of services to persons with substantial disabilities. Additionally, the Council serves as the State's Special Education Advisory Committee (AS 14.30.231), the Interagency Coordinating Council for Infants and Toddlers with Disabilities (AS 47.20.060), acts as the Board of Directors for the Special Education Services Agency (AS 14.30.610) and provides the Alaska Mental Health Trust Authority with recommendations about the Comprehensive Integrated Mental Health Plan (AS 47.30.036 (3)).

AS 47.30.666 Alaska Mental Health Board
The AMHB is tasked with:

- Developing a comprehensive plan for mental health services and priorities for annual implementation.
- Evaluating the effectiveness of mental health services and programs.
- Providing a public forum on various mental health issues.
- Advocating for the needs of mental health consumers before the Governor.
- Legislature, Alaska Mental Health Trust Authority (Trust), executive agencies and the public.

Providing recommendations to the Trust on the state mental health budget and the comprehensive, integrated mental health program for the state; and
Submitting period reports regarding its planning, advocacy, evaluation and other activities.

AS 44.29 Advisory Board on Alcoholism and Drug Abuse
The board acts in an advisory capacity to the legislature, the governor, and state agencies in the following matters:

Special problems affecting mental health that alcoholism or drug abuse may present:

- Educational research and dissemination of public information regarding the problems presented by alcoholism or drug abuse.
- Social problems that affect rehabilitation of alcoholics and drug abusers.
- Legal processes that affect the treatment and rehabilitation of alcoholics and drug abusers.
- Development of programs of prevention, treatment and rehabilitation for alcoholics and drug abusers.
- Evaluation of effectiveness of alcoholism and drug abuse programs in the state.

The board provides recommendations to the Alaska Mental health Trust Authority for its review and consideration concerning the integrated comprehensive mental health program for people who are described in AS 47.30.056(b)(3), and concerning the use of money in the mental health trust settlement income account in a manner consistent with regulations adopted under AS 47.30.031.

The board is the planning and coordinating body for purposes of federal and state laws relating to alcohol, drug, and other substance abuse prevention and treatment services.

The board prepares and maintains a comprehensive plan of services for the prevention and treatment of alcohol, drug, and other substance abuse, and for beneficiaries of the Alaska Mental Health Trust. The current iteration is “Results Within Our Reach, The Alaska State Plan for Alcohol and Drug Abuse Services, 1999-2003.”

Alaska Mental Health Trust Authority Projects
AMHB Infrastructure and Coordinated Public Education Project. This project is to develop a coordinated public campaign. The AMHB has a small amount of MHTAAR funding for mental health public education in the current fiscal year FY2002. In order to carry out a coordinated campaign, resources at the disposal of the four boards for that purpose (beyond those already available to the AMHB) are necessary. The AMHB proposes to be the clearinghouse for funds which would be devoted to those elements of a coordinated strategic communications plan (as developed by the four-board group established at the May 2001 collaboration meeting) which require outside consulting or products such as:

- A resource guide to beneficiary programs.
- Media consulting and products.
- Outreach development and coordination.

A group consisting of the four boards and other stakeholders will develop the plan from the specific elements this increment funds.

Public Awareness Campaign Project
This project was funded by the Trust in FY2002. This increment is critical to continuing development of an on-going public awareness campaign that:

- Increases community awareness of mental health/illness issues.
- Reduces the stigma and discrimination associated with mental illness.
- Promotes broad based support for mental health treatment and support services.

The continued campaign will build upon themes in the Surgeon General's Report on Mental Health: mental health is indispensable to overall health; mental illness has a devastating social impact; treatment works; and significant barriers to adequate mental health services exist. FY2003 increased funding will allow the AMHB to continue a comprehensive, year-round campaign focusing on:

- Educational presentations on mental health/mental illness to multiple audiences.
- A statewide program of activities for May is Mental Health month.
- A resource directory for mental health-related services in communities statewide.
- Enhanced media relations.

Some or all of these funds may be employed in support of a collaborative public education campaign involving the Alaska Mental Health Trust Authority, the Advisory Board on Alcoholism and Drug Abuse, the Alaska Commission on Aging, and the Governor's Council on Disabilities and Special Education.

Alaska Mental Health Trust Authority Projects
The Council is federally funded to fulfill specific roles mandated by Congress. It is an expectation of the Trust that the Council will participate in planning, implementing and funding a comprehensive integrated mental health program that serves people with developmental disabilities and their families. Financial support for this work has not been received from the Trust.

This request, which is consistent with the Trust's own needs for increased staff, will provide for a Research Analyst and associated operating funds needed to help ensure Council activities are conducted within the framework of the Trust's guiding principals while still meeting congressional requirements. Without these funds, the Council's ability to provide up-to-date, valid information to the Trust on consumer issues, identify trends, participate in Trust activities, enhance public awareness, and engage in ongoing collaboration with the Trust and the other three boards will be sorely compromised.

The research analyst will design, conduct, analyze and report on in-depth research studies to provide timely, accurate data for planning purposes. The position will evaluate the implementation of all recommendations made by the Council to the Trust to identify service delivery systems impact, provide information to update ongoing plans and projects, develop new recommendations and plans, and prepare proposals and applications for other resources.
The Council is also asking for an increase in Interagency Receipts. This is to receive funding for the Personal Assistance Services and Support (PASS) Grant from the Division of Senior Services. These funds will be used to complement the Council's recruitment and retention activities (e.g. developing a public information campaign to increase the respect and value of direct service workers; establishing a direct service worker association; coordinating recruitment efforts and sharing innovative recruitment strategies across agencies).

Alaska Mental Health Trust Authority Projects
Title 47 Statewide Initiative Project. This is an increment to the MHTAAR project that started in FY2002. The goal of this project is to increase the appropriate use of the Title 47 Alcohol/Drug Commitment Statute to reduce health risks, deaths, and negative consequences of alcohol/other drugs statewide. This is to be accomplished through contractual training and technical support across disciplines/professions for persons dealing with the target population of individuals eligible for Title 47 alcohol/other drug involuntary commitments.

This project is aimed at strengthening the ability of providers and other authorized persons to utilize the Title 47 Commitment Statute to protect residents who are late stage, chronically substance dependent or other statutorily eligible individuals. Such persons must be incapable of realizing and making rational decisions with respect to the need for treatment and be unable to take care of their basic safety or personal needs including food, clothing, shelter or medical care.

The project will also coordinate with the Jail Alternative Services (JAS) program, which provides case coordination for mentally ill offenders. The contractor will coordinate meetings among the Department of Corrections, Division of Mental Health & Developmental Disabilities, and the Division of Alcoholism and Drug Abuse. Medical implications are expected but their extent is not yet known.

ADA Board Infrastructure and Coordinated Public Education Project. This increment is to strengthen the accomplishment of the ABADA mission. With this increment, ABADA planning efforts as well as accomplishing most research functions will fund selected research contracts to meet planning and advocacy priorities, including full participation in the Trust/Boards Strategic Communications Initiative currently under development. This initiative would increase public awareness and support for beneficiary needs and reduce the stigma so frequently attached to beneficiaries. Additional workspace, storage space and a workstation to support ongoing print document distribution, conference space for small meetings with stakeholders and visitor seating is needed.

Appendices

BRU/Component Listing FY 2003

BRU Name	Component Name
Public Assistance	Alaska Temporary Assistance Program
Public Assistance	Adult Public Assistance
Public Assistance	General Relief Assistance
Public Assistance	Old Age Assistance-Alaska Longevity Bonus (ALB) Hold Harmless
Public Assistance	Permanent Fund Dividend Hold Harmless
Public Assistance	Energy Assistance Program
Public Assistance	Tribal Assistance Programs
Medical Assistance	Medicaid Services
Catastrophic and Chronic Illness Assistance	Catastrophic and Chronic Illness Assistance
Public Assistance Administration	Public Assistance Administration
Public Assistance Administration	Quality Control
Public Assistance Administration	Public Assistance Field Services
Public Assistance Administration	Fraud Investigation
Public Assistance Administration	Public Assistance Data Processing
Public Assistance Administration	Work Services
Public Assistance Administration	Child Care Benefits
Medical Assistance Administration	Medical Assistance Administration
Medical Assistance Administration	Medicaid State Programs
Medical Assistance Administration	Health Purchasing Group
Medical Assistance Administration	Certification and Licensing
Medical Assistance Administration	Hearings and Appeals
Children's Health Eligibility	Children's Health Eligibility
Purchased Services	Family Preservation
Purchased Services	Foster Care Base Rate
Purchased Services	Foster Care Augmented Rate
Purchased Services	Foster Care Special Need
Purchased Services	Foster Care Alaska Youth Initiative
Purchased Services	Subsidized Adoptions & Guardianship
Purchased Services	Residential Child Care
Purchased Services	Court Orders and Reunification Efforts
Family and Youth Services	Front Line Social Workers
Family and Youth Services	Adoption Placement Program
Family and Youth Services	Family and Youth Services Management

Family and Youth Services	Family and Youth Services Training
Balloon Project	Balloon Project
Juvenile Justice	McLaughlin Youth Center
Juvenile Justice	Fairbanks Youth Facility
Juvenile Justice	Nome Youth Facility
Juvenile Justice	Johnson Youth Center
Juvenile Justice	Bethel Youth Facility
Juvenile Justice	Mat-Su Youth Facility
Juvenile Justice	Ketchikan Regional Youth Facility
Juvenile Justice	Delinquency Prevention
Juvenile Justice	Probation Services
Children's Trust Programs	Children's Trust Programs
Human Services Community Matching Grant	Human Services Community Matching Grant
Maniilaq	Maniilaq Social Services
Maniilaq	Maniilaq Public Health Services
Maniilaq	Maniilaq Alcohol and Drug Abuse Services
Maniilaq	Maniilaq Mental Health and Developmental Disabilities Services
Norton Sound	Norton Sound Social Services
Norton Sound	Norton Sound Public Health Services
Norton Sound	Norton Sound Alcohol and Drug Abuse Services
Norton Sound	Norton Sound Mental Health and Developmental Disabilities Services
Southeast Alaska Regional Health Consortium	Southeast Alaska Regional Health Consortium Public Health Services
Southeast Alaska Regional Health Consortium	Southeast Alaska Regional Health Consortium Alcohol and Drug Abuse
Southeast Alaska Regional Health Consortium	Southeast Alaska Regional Health Consortium Mental Health Services
Kawerak Social Services	Kawerak Social Services
Tanana Chiefs Conference	Tanana Chiefs Conference Public Health Services
Tanana Chiefs Conference	Tanana Chiefs Conference Alcohol and Drug Abuse Services
Tanana Chiefs Conference	Tanana Chiefs Conference Mental Health Services
Tlingit-Haida	Tlingit-Haida Social Services
Tlingit-Haida	Tlingit-Haida Alcohol and Drug Abuse Services
Yukon-Kuskokwim Health Corporation	Yukon-Kuskokwim Health Corporation Public Health Services
Yukon-Kuskokwim Health Corporation	Yukon-Kuskokwim Health Corporation Alcohol and Drug Abuse Services
Yukon-Kuskokwim Health Corporation	Yukon-Kuskokwim Health Corporation Mental

	Health Services
State Health Services	Nursing
State Health Services	Women, Infants and Children
State Health Services	Maternal, Child, and Family Health
State Health Services	Healthy Families
State Health Services	Public Health Administrative Services
State Health Services	Epidemiology
State Health Services	Bureau of Vital Statistics
State Health Services	Health Information & System Support
State Health Services	Health Services/Medicaid
State Health Services	Community Health/Emergency Medical Services
State Health Services	Community Health Grants
State Health Services	Emergency Medical Services Grants
State Health Services	State Medical Examiner
State Health Services	Infant Learning Program Grants
State Health Services	Public Health Laboratories
State Health Services	Tobacco Prevention and Control
Alcohol and Drug Abuse Services	Alcohol and Drug Abuse Administration
Alcohol and Drug Abuse Services	Alcohol Safety Action Program (ASAP)
Alcohol and Drug Abuse Services	Alcohol and Drug Abuse Treatment Grants
Alcohol and Drug Abuse Services	AK Fetal Alcohol Syndrome Program
Alcohol and Drug Abuse Services	Community Action Prevention & Intervention Grants
Alcohol and Drug Abuse Services	Correctional ADA Grant Services
Alcohol and Drug Abuse Services	Rural Services and Suicide Prevention
Alcohol and Drug Abuse Services	Community Grants - Prevention
Alcohol and Drug Abuse Services	Community Action Against Substance Abuse Grants
Alcohol and Drug Abuse Services	Rural Services Grants
Community Mental Health Grants	General Community Mental Health Grants
Community Mental Health Grants	Psychiatric Emergency Services
Community Mental Health Grants	Services to the Chronically Mentally Ill
Community Mental Health Grants	Designated Evaluation and Treatment
Community Mental Health Grants	Services for Seriously Emotionally Disturbed Youth
Community Developmental Disabilities Grants	Community Developmental Disabilities Grants
Institutions and Administration	Mental Health/Developmental Disabilities Administration
Institutions and Administration	Alaska Psychiatric Institute
Mental Health Trust Boards	Alaska Mental Health Board
Mental Health Trust Boards	Governor's Council on Disabilities and Special

	Education
Mental Health Trust Boards	Advisory Board on Alcoholism and Drug Abuse
Administrative Services	Commissioner's Office
Administrative Services	Personnel and Payroll
Administrative Services	Administrative Support Services
Administrative Services	Health Planning & Facilities Management
Administrative Services	Audit
Facilities Maintenance	Facilities Maintenance
Facilities Maintenance	HSS State Facilities Rent

Glossary of Acronyms

ABADA ..... Advisory Board on Alcoholism and Drug Abuse
ABDR ..... Alaska Birth Defects Registry
ADA ..... Division of Alcohol and Drug Abuse
AFDC ..... Aid to Families with Dependent Children
AFHCAN..... Alaska Federal Health Care
AJJAC ..... Alaska Juvenile Justice Advisory Committee
ALBHH ..... General Relief Medical to Alaska Longevity Bonus Hold Harmless
AMHB ..... Alaska Mental Health Board
AMHTA ..... Alaska Mental Health Trust Authority
APA ..... Adult Public Assistance
API..... Alaska Psychiatric Institute
APHIP ..... Alaska Public Health Improvement Process
ARND..... Alcohol and Related Neurodevelopmental Disorder
ARBD..... Alcohol Related Birth Defects
ASAP..... Alcohol Safety Action Program
ASTHO..... Association of State & Territorial Health Officials
ATAP..... Alaska Temporary Assistance Program
ATCA ..... Alaska Tobacco Control Alliance
ATSDR..... Agency for Toxic Substances and Disease Registry
AVCP ..... Association of Village Council Presidents
AYI..... Alaska Youth Initiative
BRFSS ..... Behavioral Risk Factor Surveillance System
BRU..... Budget Request Unit
BVS ..... Bureau of Vital Statistics
CAASA ..... Community Action Against Substance Abuse
CAHPS ..... Consumer Assessment of Health Plans Survey
CAMA ..... Chronic and Acute Medical Assistance
CCDF..... Child Care Development Fund
CDC..... Center for Disease Control
CDFA ..... Catalogue of Federal Domestic Assistance
CHEMS ..... Community Health & Emergency Medical Services
CHIP..... Children's Health Insurance Program
CIMHP ..... Comprehensive Integrated Mental Health Plan
CMHC ..... Community Mental Health Center
CMI ..... Chronically Mentally Ill
CMS..... Center for Medicare and Medicaid Services
COMPASS ..... Community Partnership for Access Solutions and Success
CSAT ..... Center for Substance Abuse Treatment

CSN ..... Children with Special Needs
DAS ..... Division of Administrative Services
DE&ED ..... Department of Education & Early Development
DET ..... Designated Evaluation & Treatment
DEU ..... Data Evaluation Unit
DFYS ..... Division of Family and Youth Services
DHSS ..... Department of Health and Social Services
DJJ ..... Division of Juvenile Justice
DKC ..... Denali KidCare (State Children's Health Insurance Program)
DOT ..... Direct Observed Therapy
DMA ..... Division of Medical Assistance
DPA ..... Division of Public Assistance
DSH ..... Disproportionate Share Hospital
DWI ..... Driving While Intoxicated
EAP ..... Energy Assistance Program
EBT ..... Electronic Benefit Transfer
EI ..... Early Intervention
EIS ..... Eligibility Information System
EMS ..... Emergency Medical Services
EPI ..... Epidemiology
EPSDT ..... Early & Periodic Screening, Diagnosis and Treatment
FAE ..... Fetal Alcohol Effects
FARS ..... Fatal Accident Reporting System
FAS ..... Fetal Alcohol Syndrome
FASD ..... Fetal Alcohol Spectrum Disorder
FMAP ..... Federal Medical Assistance Program
FS ..... Food Stamps
FTE ..... Full Time Equivalent
GCDSE ..... Governor's Council on Disabilities and Special Education
GRA ..... General Relief Assistance
GRM ..... General Relief Medical
HAIL ..... Healthy Alaskans Information Line
HAN ..... Health Alert Network
HAP ..... Heating Assistance Program
HCFA ..... Health Care Financing Administration
HCP ..... Health Care Program
HIFA ..... Health Insurance Flexibility and Accountability
HIPP ..... Health Insurance Premium Payment (Medicaid)
HISS ..... Health Information and Systems Support
HRSA ..... Health Resource Services Administration

IA ..... Interim Assistance
IHS ..... Indian Health Services
ILLECP ..... Local Law Enforcement & Community
ILP ..... Infant Learning Program
JJDP ..... Office of Juvenile Justice and Delinquency Prevention
JPO ..... Juvenile Probation Officer
JTPA ..... Job Training Partnership Act
LIHEAP ..... Low Income Home Energy Assistance Program
MCAC ..... Medicaid Care and Advisory Committee
MCFH ..... Maternal, Child, & Family Health
MHDD ..... Mental Health and Developmental Disabilities
MHTAAR ..... Mental Health Trust Authority Authorized Receipts
MIS ..... Management Information System
MMIS ..... Medicaid Management Information System
MOA ..... Municipality of Anchorage or Memorandum of Agreement
MOE ..... Maintenance of Effort
MYC ..... McLaughlin Youth Center
NPS ..... National Pharmaceutical Stockpile
NRO ..... Northern Region Office
OEP ..... Office of Emergency Preparedness
PASS ..... Parents Achieving Self-Sufficiency
PC ..... Personal Computer
PCCM ..... Primary Care Case Management
PCN ..... Position Control Number
PHN ..... Public Health Nursing
PIC ..... Private Industry Council
POP ..... Persistent Organic Pollutants
PPC ..... Prevention Policy Committee
PRAMS ..... Pregnancy Risk Assessment Monitoring System
PRWORA ..... Personal Responsibility and Work Opportunity Reconciliation Act
RDT ..... Residential Diagnostic Treatment
RFP ..... Request for Proposal
RFR ..... Request for Recommendations
RPMS ..... Resources and Patient Management System
RSA ..... Reimbursable Services Agreement
SAMHSA ..... Substance Abuse and Mental Health Services Administration
SCHIP ..... State Children's Health Insurance Program
SCRO ..... Southcentral Region Office
SECC ..... State Emergency Coordination Center
SED ..... Seriously Emotionally Disturbed

SERO ..... Southeast Region Office
SIG/ACT ..... State Incentive Grant/Alaskans Collaborating for Teens
SME ..... State Medical Examiner
SMI ..... Supplementary Medical Insurance
SSBG ..... Social Services Block Grant
STD ..... Sexually Transmitted Disease
TANF ..... Temporary Assistance to Needy Families
TB ..... Tuberculosis
TCC ..... Tanana Chiefs Conference
TEFRA ..... Tax Equity and Fiscal Responsibility Act of 1982
TFAP ..... Tribal Family Assistance Programs
Title V ..... Maternal, Child Health Block Grant
Title X ..... Family Planning (Federal)
Title XIX ..... Medicaid
Title XXI ..... SCHIP/Denali KidCare
T&H ..... Central Council of Tlingit and Haida Indian Tribes
TWWIIA ..... Ticket to Work and Work Incentives Improvement Act of 1999
USDA ..... U. S. Department of Agriculture
WIC ..... Women, Infants and Children
WtW ..... Welfare to Work
YF ..... Youth Facility
YKHC ..... Yukon-Kuskokwim Regional Health Corporation
YRBS ..... Youth Risk Behavior Survey